

INVESTIGATION OF TRANSPARENCY AND ECONOMIC EFFICIENCY IN THE USE OF THE NATIONAL HEALTH INSURANCE COMPANY'S FUNDS

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ABBREVIATIONS

MA – Medicines Agency

CHI – compulsory health insurance

TA – Territorial Agencies (of the NHIC)

NBS – National Bureau of Statistics

MB – Management Board (of the NHIC)

CA – Court of Accounts

ICD – International Classification of Diseases

NHIC – National Health Insurance Company

NHAAC – National Health Assessment and Accreditation Council

CHIF – Compulsory Health Insurance Funds

GD – Government Decision

MSTI – Main State Tax Inspectorate

HCF – health care facility

MH – Ministry of Health

WHO – World Health Organization

PAYG – “pay as you go” financing principle

GDP – Gross Domestic Product

PPP – purchasing power parity

IAS – Internal Audit Service (of the NHIC)

SHIS – Social Health Insurance System

CSS – Centralized State System

NHCS – National Health Care Service

USD – US dollar

EXECUTIVE SUMMARY

The Republic of Moldova is ranked low by most indicators measuring the population's health, which denotes both existence of some flaws in the health care system of the Republic of Moldova and this system's relatively high financing needs. Indeed, the share of health care expenses in the GDP of Moldova is the highest among the states in this region, with public expenses covering only one half of all expenses. Certainly, such a high share of health care expenses in the GDP, and especially of private expenses, may reflect both very high financing needs and the inefficiency of public expenses.

Our country has serious issues in the health care system operation. This means negative consequences on the population's health, human capital quality and citizens' trust in the future of this country. Consequently, emigration trends grow stronger and corruption in the health care system becomes increasingly acute.

Implementation of the compulsory health insurance in the Republic of Moldova in 2004 enabled the health care system, negatively affected during the country's transition to market economy, to revive. Nonetheless, health insurance represents just one of the elements important for efficient operation of a health care system. In this respect streamlining the health insurance system is impossible without reformation of the health care system. The analysis of the institutional framework the National Health Insurance Company (NHIC) operates in highlights an excessive structural and functional complexity of the health care sector, which creates large costs for maintenance of the excessive infrastructure; an insufficient functional delimitation of duties between the NHIC and the Ministry of Health in respect to development of policies and financing of the health care system; service package insufficiently aligned to the population's real needs; poor quality of the contracted medical services; inappropriately regulated health care workers' individual professional performance; deficient policies of accreditation by the National Health Assessment and Accreditation Council; etc. Analyzed on the whole these issues influence the NHIC's role as the main funder of the health care system considerably. For these reasons the proposed recommendations refer to the whole health care system rather than just to the Company. Particularly, there is a need to increase the NHIC's autonomy in relation to CHIF management, to prevent the NHIC to finance activities that are not directly related to the compulsory health insurance as well as to improve the capacities to monitor performance and sanction health care service providers for irregularities admitted in their services.

The NHIC has a paramount role in health insurance process. Of course, the results of this process are not exclusively determined by the NHIS, they also depend on the success of reforms in the health care sector, the country's social and economic development particularities, etc. Accordingly, many of these aspects should be tackled by the NHIC jointly with other important public actors. Besides, some progress may be secured by improvement of the institutional governance and the Company's executive management. The study draws the readers' attention to a range of problematic aspects related to: internal institutional governance, including assessment of internal performance within the NHIC and relationship with service providers. Both aspects have an important impact on the efficiency and control of the CHIF usage. The study offers recommendations aimed at removing the highlighted disadvantages by consolidating the role of the NHIC Management Board, which often had a purely formal role, improving the representation of beneficiaries of the compulsory health insurance system in the NHIC Management Board and consolidating the internal control over the NHIC staff's performance.

Another major problem of the system in its current state consists in low coverage by compulsory health insurance and low share of persons who contribute directly to

this system. Thus, around 30% of Moldovan population remain noninsured and only 34% of the insured individuals contribute directly, while others fall within the categories that are insured by the Government for whom transfers from the state budget are much lower than the cost of the insurance policy or the average percentage contribution paid by employers and employees. This creates an excessive burden and unfair relation between those who contribute and those who do not contribute to financing of the system. At the same time, those who are not obliged to pay health insurance premiums avoid to do this both for financial reasons (lower income that do not allow procurement of an insurance policy) and for other reasons. The fact that the current system is perceived as an inefficient and unfair one, that the services quality does not meet the population's expectations and needs, that the Government guarantees a minimal health care service package, the possibility to purchase and activate the health insurance policy at any moment of the year – all these demotivate the population from participating actively in the current health insurance system. Currently there are no efficient instruments to discipline the population in respect to health insurance (particularly, those who are not employed), save for a few categories (lawyers, notaries, patent holders).

Increase of the percentage contribution and of the fixed amount contribution, as planned for the following four years, will not solve the fundamental problems of the system without improvement of the quality of the health care service providers and creation of a fair system, where the financial burden will not be laid only on the shoulders of such a narrow segment of the population. Thus, there is a need to implement a wider range of instruments aimed at increasing the health insurance coverage level among the non-payers (including not just incentives, but also sanctions) as well as to develop schemes of motivating large payers whom the current system does not satisfy. Moreover, the NHIC, as an insurance company, should put forward stricter requirements to health care service providers, without being influenced by relations it has with the Ministry of Health and by no means finance activities that are inappropriate for an insurance company. These would help optimize the health expenses.

Undoubtedly, for the health insurance system to operate well and for the reforms to be successfully implemented we need human, financial and technical resources as well as a clear delimitation of responsibilities between various actors and a total understanding of the context the current health insurance system operates in. Today some duties of the NHIC do not relate to its responsibility directly, the responsibilities are scattered among various institutions, which results in inefficiency. After these responsibilities are clearly delimited, the capacities of all institutions involved in the process should be consolidated in order to achieve efficiency and fairness of decisions to be taken in the future.

INTRODUCTION

This study aims at investigating the economic efficiency and financial transparency of how the National Health Insurance Company uses public funds as well as some aspects related to operation of health care service providers in terms of institutional organization.

The Republic of Moldova has serious issues with operation of the health care system. This implies negative consequences on the population's health, quality of human capital and citizens' trust in the future this country may offer to them. Consequently, emigration trends grow stronger and corruption in the health care system becomes increasingly acute

One of these fundamental issues of the health care system is the strong financial vulnerability caused by demographic trends and unfavorable demographic and health trends as well as by some conceptual problems in operation of the health care system. The system is almost exclusively based on the principle of social solidarity, leaving little room for private systems and discouraging from revealing the wages. Another range of serious problems is related to insufficient financial transparency in formation and use of the respective funds, which leads to suboptimal usage of some important sums of public money, with no effect on the social welfare.

Although numerous policies and strategies for health insurance reform have been adopted at the Government level, their implementation leaves much to be desired. For instance, extension of the population's coverage by the health insurance system bumps up against a widespread problem of rural poverty.

Besides structural problems that compound the operation of the system, there is a range of problems directly related to the financial management, which are confirmed in multiple decisions of the Court of Accounts:

- Low transparency in budget spending;
- Low level of coverage of the population by the compulsory health insurance system;
- Inefficient use of earmarked funds;
- Problems in functioning of information components;
- Lack of transparency in public procurement;
- Misstatement of the amount of the provided health care services.

The authors intend to analyze the model of funding the health care system as a whole and to formulate recommendations for improvement of the system operation. To achieve the project aim, the Expert-Group's team has analyzed needs and possibilities for financing the health care system, the conceptual organization of the NHIC's systems and tax and social justice aspects in the NHIC funds formation.

1. ECONOMIC AND SOCIAL CONTEXT

This chapter analyzes fundamental factors determining the viability of the current health care system: financing needs and capacities. The financing needs depend on the life expectancy at birth and the general health of the population, which were taken in regional context, as well as on the morbidity evolution. Demographic trends influence both the financing needs and the financing capacities; therefore, we used time spans which include forecasts for until 2020. Besides, we have analyzed trends on the labor market that determine the burden of financing the health care system.

1.1. HEALTH CARE SYSTEM FINANCING NEEDS

In this subchapter we intend to examine the factors determining and modeling the financing needs in health care. These factors reflect in large part the population's health condition – life expectancy at birth, morbidity, etc. – and the risk factors, such as obesity or smoking. The healthier the population and the lower the risks for health, the lower the financial burden for the health care system might be and the lower the health insurance needs are. Besides, we will try to examine Moldova in the regional context to see whether challenges and risks Moldova encounters are specific for other countries in the same region and, respectively, whether some regional solutions are, at least hypothetically, applicable in Moldova.

On the whole, it is worth mentioning that Moldova ranks low compared to most countries in this region, with quite modest progress achieved over the past 8 years. As far as we can see (Table 1, Table 2) fundamental indicators such as adult and child mortality are disadvantageous for the Republic of Moldova compared to countries from the same region. Other indicators also push the balance to the disadvantage of Moldova.

TABLE 1. LIFE EXPECTANCY AT BIRTH, HEALTHY LIFE EXPECTANCY AND YEARS OF LIFE SPENT IN POOR HEALTH, COUNTRIES SELECTED FROM THE SAME REGION.

	Life expectancy at birth (years)				Healthy life expectancy*	Years of life spent in poor health**
	2000	2008	2010-2015	2015-2020	2008	2008
Bulgaria	72	73	74.3	75.2	66	7
Romania	71	73	73.8	74.8	65	8
Ukraine	68	68	69.1	70.3	60	8
Estonia	71	74	74.3	75.5	66	8
Slovakia	73	75	75.6	76.4	67	8
Moldova	68	69	69.3	70.2	61	8

*Notes: * "Healthy life expectancy" at birth represents an average number of years a person may expect to live in "good health condition", by taking into consideration the number of years spent in poor health due to illness and/or trauma. As a result, this indicator comprises "fatal" and "non-fatal" health results, of which hearing and sight impairments as well as mental disorders are the most globally widespread (WHO);** - Difference between the life expectancy and healthy life expectancy, Mihaljek (2007).*

Source: WHO, World Health Report 2010.

Thus, we can see that in the Republic of Moldova not only the life expectancy is quite short, but also the healthy life expectancy is reduced, which means that on average a Moldovan citizen lives fewer healthy years and, consequently, ends his/her role as a payer to the health care system earlier and also becomes a "client" of this system earlier. However, if we examine the years of life spent in poor health, we can see that this indicator is at the level of regional figures, which means about the same number of years of intense benefitting of health care services for Moldovans as for citizens from other countries in the same region.

TABLE 2. ADULT AND CHILD MORTALITY RATE, 2000 AND 2008.

	Adult mortality rate*		Child mortality rate	
	2000	2008	2000	2008
Bulgaria	160	153	13.3	8.6
Romania	173	156	18.6	11
Ukraine	257	277	11.9	10.4
Estonia	218	165	8.4	5
Slovakia	147	135	8.6	5.9
Moldova	232	227	18.3	12.2

Notes: * The probability of decease between 15 and 60 years per 100 persons.

Source: WHO, World Health Statistics 2010.

Further it is useful to examine the causes of the mortality by groups of illness (communicable, noncommunicable and accidents) and so called “years of life lost”¹, which also rank the Republic of Moldova at a relatively less favorable position compared to some countries from the same region (Table 3) and reveal an insufficient attention paid to preventable risks² (Table 4). Indeed, according to these data the existence of risk factors in Moldova ranks it in the lower part (i.e. with stronger risks) of the regional ranking.

At the same time, data on morbidity show a rather negative evolution over the past 5 years for most categories of diseases (Figure 1). This alarming evolution will obviously affect the financing needs to combat them.

TABLE 3. CAUSES OF MORTALITY (STANDARDIZED BY AGE, PER 100 000 PERSONS) AND DISTRIBUTION OF LOST YEARS BY CAUSES (% FROM THE TOTAL LOST YEARS), 2004.

	Causes of mortality / Distribution of lost years		
	communicable	noncommunicable	accidents
Bulgaria	32/5	733/87	42/8
Romania	51/9	706/79	54/12
Ukraine	61/9	881/72	130/19
Estonia	33/5	664/72	113/22
Slovakia	35/5	628/82	48/13
Moldova	64/10	963/74	97/16

Notes: * An average age structure for the world population for 2000 – 2025,

<http://www.who.int/healthinfo/paper31.pdf>;

Source: WHO, World Health Report 2010.

TABLE 4. RISK FACTORS FOR ADULTS AGED OVER 15 (%).

	Obesity		Smoking		Alcohol consumption
	Men	Women	Men	Women	Total
Bulgaria	13.4	19.2	49	38	12.4
Romania	7.7	9.5	45.5	24.1	15.3
Ukraine		4.1	18.9	4.2	15.6
Estonia	17.5	18.3	47.8	25.3	15.6
Slovakia	13.5	15	41.3	20.3	13.3

¹ “Years of life lost” (YLL) is a measure of premature mortality that relates both to frequency of diseases and to the age when these occur. The YLL takes into account the age when the disease occurs by giving larger shares to diseases occurring at younger ages and smaller shares to diseases occurring at older ages.

² Untreated water and lack of water treatment services; use of solid fuel in households; light weight at birth; poor new-born feeding practices; malnutrition of children; overweight or obesity; excessive alcohol consumption; smoking; unprotected sex.

Moldova

18.2

44.7

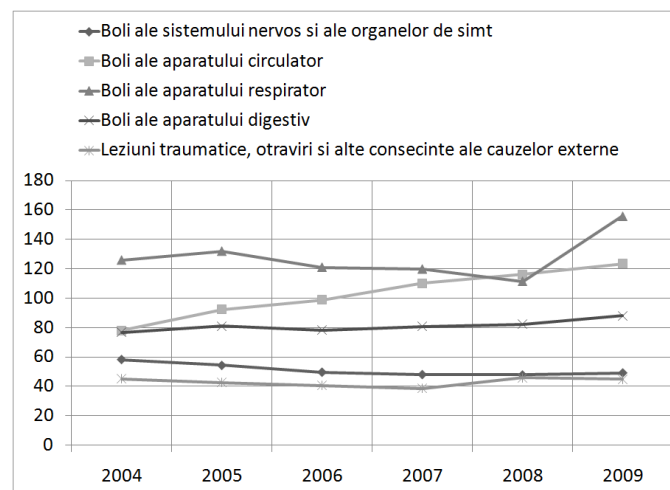
5.4

19.2

Notes: * Population of 15 and more years, pure alcohol liters, 2003 – 2005.

Source: WHO, World Health Report 2010.

FIGURE 1. EVOLUTION OF THE MORBIDITY BY DISEASES CLASSES, REGISTERED ILL PERSONS PER ONE THOUSAND INHABITANTS, 2004-2009.



Source: NBS.

In conclusion, we can mention that at most indicators measuring the populations' health the Republic of Moldova is ranked poorly compared to other countries from the same region, which means both the existence of deficiencies in the health care system of the Republic of Moldova and relatively high financing needs of this system.

1.2. CAPACITIES TO FINANCE THE CURRENT HEALTH CARE SYSTEM

Although theoretically Moldova has implemented the **compulsory** health insurance system in 2004, in practice this is rather a semi-compulsory system, where not all citizens are insured. In 2010 only 80.8% of the population of the country was insured and this is the maximal figure reported by the NHIC since the implementation of the current health insurance system. However, we consider that this figure is irrelevant due to the calculation method. Although the labor market was deep in the crisis in 2010, with both the employment rate and the number of employees in formal enterprises following a downwards trend³, according to the NHIC data the number of insured employees increased by 174,000 (!). However, this figure represents the number of employees for the whole year and, respectively, the number of policies active at any moment in time, whereas such a calculation needs the average number of employees for the year as reported by the NBS so far. The number of insured individuals had increased since the current health care system implementation until 2007 (with the maximal level of 76.7%), after which the economic developments, particularly those from the labor market, characterized by reduction of the employment rate and of the number of employees and, in 2009, by the reduction of the population's disposable income determined the decrease in the number of insured individuals (Table 5). Yet currently a large part of the population remains uninsured and benefits of a minimal health care service package guaranteed by the state. And in the long run the demographic trends create additional risks for the existing health insurance system.

³ According to the NBS's data from the Labor Force Survey, the average number of employees in formal positions in the enterprises of the formal sector decreased by 3.5% in 2010.

TABLE 5. THE NUMBER OF INSURED INDIVIDUALS AND THEIR SHARE IN THE TOTAL POPULATION OF THE REPUBLIC OF MOLDOVA.

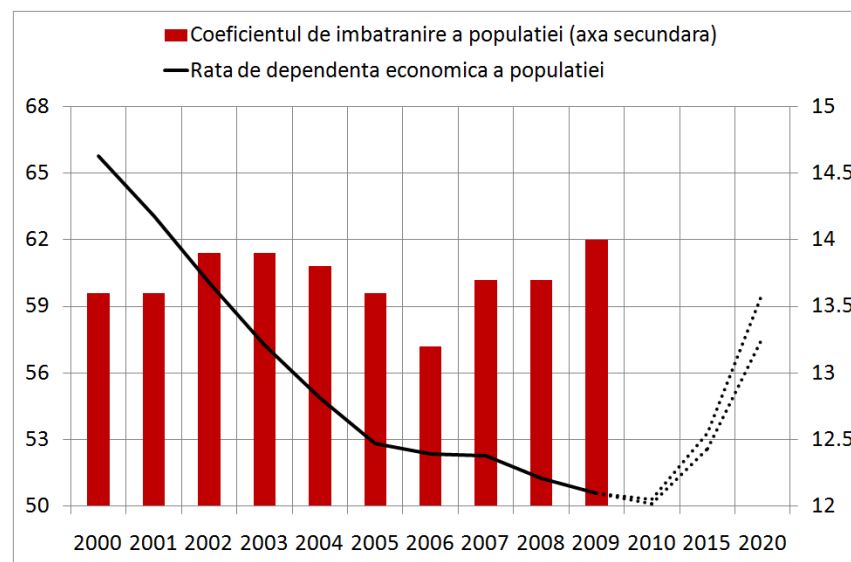
	2004	2005	2006	2007	2008	2009	2010
Number of insured individuals	2263489	2411176	2498085	2634417	2568734	2448072	2760622
Insured individuals' share in the total population, %	62.8	71.2	73.6	76.7	75.0	71.6	80,8

Source: NHIC, authors calculations based on the data of the NBS and the NHIC.

An aspect that influences the viability of the compulsory insurance system is the financing method and the structure of payers. Thus, even though about 80% of the country's population is insured, only 34%⁴ of the population actually contributes to the formation of the NHIC's budget (most of them are employees, persons who purchase insurance policies on their own accounted for just 1% of the population insured in 2009). The other 66% fall within 14 categories of persons mentioned in the Law on Compulsory Health Insurance, who are insured by the Government from the state budget.

Of them children and pensioners make the largest groups. On the whole, the dependency ratio in the Republic of Moldova is relatively high, both due to the demographic trends and to an earlier retirement age. The future prospects do not seem to be very optimistic. After the reduction of the dependency ratio during the past decade this is due to increase according to forecasts, starting with 2013, which will weaken the capacity to finance the system. Additionally, the population ageing coefficient is increasing (see Figure 2).

FIGURE 2. POPULATION'S DEPENDENCY RATIO AND AGEING COEFFICIENT.



Notes: The population ageing coefficient is the number of persons aged 60 and over per 100 inhabitants; population's dependency ratio is the number of persons at the non-working age per 100 persons of working age.

Source: NBS; The Green Book of the Population of the Republic of Moldova, UNFPA 2009, forecast for 2010-2020 from the Green Book of the Population of the Republic of Moldova, UNFPA 2009.

However, taken separately the dependency ratio is not quite a relevant indicator to determine the capacity to finance the system as long as the employment rate is very low, below 50%. This makes the burden of financing the health care system heavier

⁴ Această cifră reprezintă ponderea numărului de salariați (conform datelor BNS) în numărul total al populației asigurate (conform datelor CNAM)

than in other countries (Table 6). According to the forecasts of the International Labor Organization the employment rate is due to decrease slightly from 49.4% in 2010 down to 49.1% in 2020, though the accuracy of these forecasts is doubtful, taking into account that already in 2010 this reached 41.6% and its evolution depends not only on demographic factors, but also on economic reforms and political factors in the country.

TABLE 6. BURDEN OF FINANCING THE HEALTH CARE SYSTEM IN SOME COUNTRIES FROM THE DEMOGRAPHIC AND LABOR MARKET PERSPECTIVE.

	Dependency ratio (2010/2020)	Non-payers/Employed population (2006)	Elderly (60+)/Employed population (2008)	Unemployed/Employed population (2008)
Moldova	38/47	1,9 (2010)	0.39	0.04
Bulgaria	45/54	1.2	0.53	0.06
Estonia	48/59	1.2	0.45	0.06
Romania	43/47	1.4	0.45	0.06
Slovakia	38/45	1.6	0.37	0.11

Note: The dependency ratio calculated by the UN refers to the number of population aged 0-14 and 65+ per 100 persons aged 15-64.

Source: UN, TransMONEE, ILO, D. Mihaljek (2007) and authors' calculations based on the NBS and the NHIC's data.

The economically inactive population is one of the largest categories that do not contribute to the health insurance system. Some of its segments are insured by the Government, while others have to purchase a health insurance policy to be insured, which happens seldom. Emigrants, who make a large part of the economically "idle" population, do not contribute to the current compulsory health insurance system, most often paying formal and informal charges for services they use. Migration will keep on as an indispensable phenomenon for economic conditions of our country in the medium term, but the real risks are those for the long term, when their return home will increase even more the need for funding.

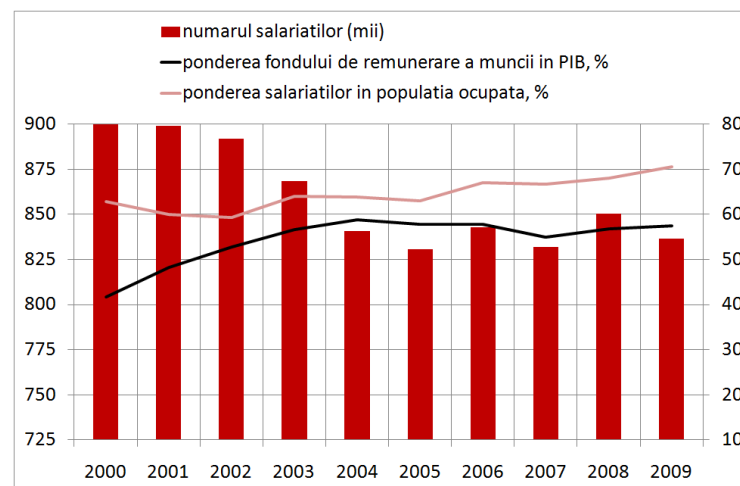
Besides, there are no means to oblige all employed population to contribute to the compulsory health insurance system. The employees are the main payers to the system and in their case it is easy to implement a mechanism of automatic deduction of the compulsory health insurance premium as percentage from the salary. However, they represent just a part of the employed population (about 70%). The other categories of the employed population (self-employed, unpaid family workers, employers, employees and members of cooperatives) are not obliged to contribute to the health insurance system by percentage contributions; instead they can purchase health insurance policies. Nevertheless, only in case of a few categories (lawyers, notaries, entrepreneurial patent holders) the control over purchase of the health insurance policy was successfully achieved, whereas the largest part (especially farmers) do not contribute and yet benefit of the same service package.

Nonetheless, the developments over the past decade show that while the employed population has kept decreasing over the respective period, there have also been periods when the number of employees increased. The decline was stronger in 2009 – 2010, when amid the economic crisis companies tried to find various methods to cut the costs and for many of them migration to informal economy was a solution.

Although return to formal economy may be a slow process, the expected increase in salaries may mitigate the impact of the formal employment decrease on the NHIC's revenue. So far there has been no positive correlation between the evolution of the number of employees and that of the work remuneration fund. Salaries growth during the past years determined the increase in the share of work remuneration

fund in the GDP, even during the years when the number of employees decreased (Figure 3). Thus, in short and medium term the financing capacities may remain unchanged given the forecasted economic growth and the expected increase of salaries.

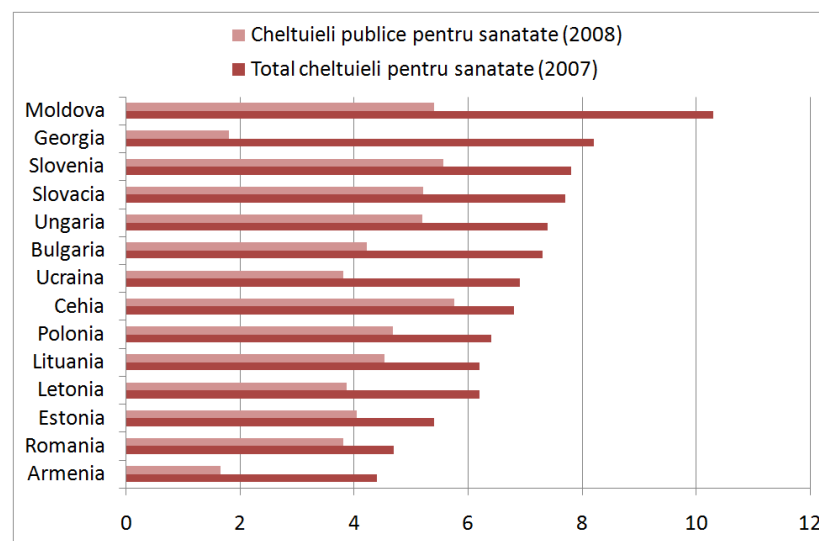
FIGURE 3. NUMBER OF EMPLOYEES, SHARE OF EMPLOYEES IN THE EMPLOYED POPULATION AND SHARE OF THE WORK REMUNERATION FUND IN THE GDP.



Source: Authors' calculations based on the NBS' data.

The demographic trends and health condition indicators show that the financing needs are quite high compared to other countries. Actually, the share of health expenses in the GDP in Moldova is the highest compared to other countries from the same region, with public expenses covering only about 50% of the total amount of expenses (Figure 4). Certainly, such a high share of health expenses in the GDP and especially of private expenses may reflect both very high financing needs and the inefficiency of public expenses. However, this financing level does not ensure similar per capita health expenses, Moldova being among the laggards in this respect. To increase them slightly we need a really spectacular growth of the economy and salaries. Otherwise even an increase of the percentage share paid by employees and employers to 13%, as intended in order to achieve the average European level, could only ensure a level of 250 USD – 300 USD per capita, which does not change Moldova's rating much.

FIGURE 4. SHARE OF HEALTH EXPENSES IN THE GDP (%).



Source: TransMONEE, WHO.

Thus, while the demographic forecasts indicate to a possible increase in the financing needs, based on the population ageing and growth of the dependency ratio, the forecasts in respect to evolution of the labor market indicate that capacities to finance the system might remain at the current level in short to medium terms due to growth of salaries and a lower volatility of the number of salaries compared to the employed population. However, given the fact that the balance between the needs and the capacities will worsen in the long term, the mechanism of financing the health care system has to be improved.

2. INSTITUTIONAL FRAMEWORK

This chapter analyzes the institutional and conceptual framework of the National Health Insurance Company (NHIC) in the compulsory health insurance system (CHIF). We have analyzed the structure, functions and mechanisms of financing the Moldovan health insurance model in the context of other existing models as well as the main actors of the health care system, the NHIC interacts with. Seen as the whole these institutional aspects influence the functioning of the entire health care system in the long term.

2.1. MOLDOVAN HEALTH INSURANCE SYSTEM FINANCING MODEL

This subchapter analyzes various financing models existing within the CHI system, the CHI legislative and regulatory framework, the NHIC's role and functions in the CHI as well as the service package the NHIC provides to customers.

HEALTH CARE SYSTEMS FINANCING MODELS

European public health care systems are structured on the basis of three financing models:

- a) Beveridge – the national health care service (NHCS);
- b) Bismarck – the social health insurance system (SHIS);
- c) Semasko – the centralized state system (SSC).⁵

The UK, Norway, Denmark, Sweden, Finland, Ireland, Italy, Spain, Portugal and Greece use Beveridge model, developed and proposed by Britons. The main financing source of this model draws on general taxes. Health care services are accessible to all citizens, with a general coverage. A part of health care services are paid by the beneficiary. Doctors are remunerated by salaries or on the per capita basis, depending on the number of serviced beneficiaries. The Beveridge model has proven its positive impact on the general health of the population. The model's disadvantages include: long waiting lists (mainly for complex surgical services), excessive bureaucracy in servicing the model and lack of a proper and efficient mechanism of motivating the health care staff.

Netherlands, Belgium, Luxembourg, Switzerland, France, Germany and Austria use Bismarck model. This model combines the elements of social insurance (age pensions, temporary disability benefits) and health insurance (sickness benefits). For the time being this is the most widespread model in Europe. This model has its own characteristics and particularities depending on the country applying it. The general operating principle is based on collection of general taxes depending on income, where the employees and the employers are obliged to contribute through fees. The coverage level is high, but there are categories of population who are deprived of access to the system's benefits. The funds are managed by special organizations or agencies. In their turn these contract hospitals and family doctors. The family doctors are contracted on a fee-per-service basis, while for hospitals global budgets are negotiated. The health issues are addressed mainly from a curative approach, focused on treatment instead of prevention of diseases. Only in exceptional situations preventive and health promotion measures are contracted. The model's administrative costs are high, but so are the achieved medical performances.

The third, Semasko financing model was inherited from the Socialist governance model and is specific for the Central and East Europe countries under transition from

⁵ Typology description according to http://www.univermed-cdgm.ro/dwl/glosar_termeni_L-Z.pdf.

the centralized planning system to a market based one⁶. The health care systems were financed from the state budget. The state held monopoly over all health care services, with the health care staff being directly employed by the state. Health care services were free of charge, the private system being absolutely inexistent. These particular features have led over time to liquidation of initiative and competence among health care staff. The health care services have become inefficient, non-performing and the quantity definitely prevailed over the quality to the latter's detriment.⁷ The excess of staff, infrastructure and services resulted in inefficiency of the appropriated funds usage. Over time an essential part of the existing health care units became underfinanced. The political priority was given exclusively to hospitals. Preventive services were inexistent. Only certain groups of population (women of reproductive age, children and teenagers, staff of enterprises at risk, etc.) were regularly checked.

COMPULSORY HEALTH INSURANCE MODEL IN THE REPUBLIC OF MOLDOVA

Introduction of the compulsory health insurance in the Republic of Moldova in 2004 enabled revival of the whole health care system, which had been considerably disintegrated during the country's transition to a market economy. Nevertheless, the unsatisfactory quality of the provided health care services, the persistence of unofficial payments, the absence of incentives for innovation both for the contractor and for the provider of health care services, abusive consumption of health care services by some categories of the population are just a few problems faced by the current Moldovan health care system on the whole and the health insurance system in particular. Further we analyze the conceptual, structural and operational particularities of the Moldovan insurance in relation to the financial needs of the health care system of the Republic of Moldova and the capacities to finance it in the long run.

Financing mechanism

The compulsory health insurance system in the Republic of Moldova was conceived on the basis of Bismarck model (SHIS). Insurance is universal and compulsory and functions on the basis of the PAYG (pay as you go) principle, where health insurance payers contribute and ensure the formation of the health insurance budget. The system is not cumulative and follows the solidarity⁸. The solidarity principle implies a compulsory contribution to the CHIF by deduction of some part from salaries. The main contributors include: the state, economically active employers and employees and individuals who perform independent economic activities. The state pays for the entire officially registered unemployed population. However, there remain groups of the population that are not covered by the health insurance system. These groups belong to economically inactive population and/or involved in informal economic activities. That is why despite the COMPULSORINESS status of the insurance, their coverage of the population is still incomplete⁹. The existent experience shows that this is difficult to regulate and check and the percentage of health insurance purchased on one's own is very low¹⁰.

⁶ Mihaela Cristina Dragoi, *Social-economic Implications of the Health Care System Reforms (Implicațiile socio-economice ale reformelor sistemelor de sănătate)*, Economic Magazine, year X, No 26, December 2007.

⁷ The World Bank, Review of Experience of Family Medicine in Europe and Central Asia: Moldova Case Study, 2005, Report No 32354-ECA.

⁸ The 2006 NHIC Functional Analysis Report, Public Administration Reform.

⁹ E. Richardson et al. Health Insurance Coverage and Health Care Access in Moldova, 2011. European Centre on the Health of Societies in Transition, London School of Hygiene and Tropical Medicine.

¹⁰ The 2010 NHIC's Annual Activity Report.

According to some sources¹¹ the compulsory health insurance premium for an employed person is almost twice as high as for persons insured by the state. This puts persons with high income and employed contributors at a disadvantage to a certain extent, compounding the already existing inequity.

Under the existing legislative framework, the National Health Insurance Company (NHIC) is the only actor responsible for¹². The NHIC's position as the only administrator of the health insurance funds, particularly at the initial stage of the reforms, enabled achieving long term stability and sustainability for health care reforms on the whole. On the other hand, the absence of competitors for the NHIC on the health insurance market undoubtedly reflects in the general efficiency of the health care system and inequity resulted from the solidarity principle. There is no competition between the health insurance funds, because the NHIC is the only and exclusive administrator of the health insurance funds. According to a recent feasibility study (February 2011)¹³ on implementation of compulsory health insurance with participation of private insurance companies in Moldova, liberalization of the health insurance market with the possibility of entering into additional contracts with private insurers would enable considerable expansion of the health insurance's income basis.

Funds are appropriated to health care service providers by means of territorial agencies (TA) of the NHIC (12 units)¹⁴, through which the Company exercises its duties throughout the country. Under GD No 559 of 10.09.2009 on Amendments to Annex No 4 of GD No 1432 of 7 November 2002 the structure of the NHIC's central apparatus and list of territorial agencies was changed.

The NHIC and TA identify and negotiate in advance with health care and pharmacy service providers. The insurer and the service provider sign a contract for health care (medical services) provision as part of the compulsory health insurance coordinated with the Ministry of Health if a republican health care service provider is the party to the contract or with the health directorate of the second level local government if other health care service providers than the republican ones are the parties to the contract, which binds the health care service provider to offer the insured individuals qualified health care in the amount and within terms provided for in the Single Program and the insurer to pay the cost of the provided health care. The contracts with health care service providers are signed for one year and usually are extended for the next year. The contracting eligibility conditions are as follows:

1. Provider's accreditation by the National Health Assessment and Accreditation Council (NHAA);
2. Provider's capacity to offer the entire amount of services for the contracted region.

Further the NHIC and the TA are involved in assessing and controlling the quality of the provided health care services.

Primary health care services are contracted on the basis of per capita principle, depending on the number of persons registered with primary health care facility.

¹¹ Notes on Health Policy. The Government of the Republic of Moldova, World Bank 2006.

¹² Law No 1585-XIII of 27.02.98 on Compulsory Health Insurance, Chapter III, Art. 12.

¹³ FSRP CS-22/LOC/IC-17/TF093288 under "Moldova Dutch TA – TF Financial Sector Reform"

¹⁴ Chisinau (Chisinau, Criuleni, Ialoveni, Straseni), 2. Balti (Balti, Falesti, Glodeni, Rascani, Sangerei), 3. Edineti (Edineti, Ocnita, Donduseni, Briceni), 4. Hancesti (Hancesti, Cimislia, Leova, Basarabasca), 5. Orhei (Orhei, Rezina, Telenesti, Soldanesti), 6. Soroca (Soroca, Floresti, Drochia), 7. Causeni (Causeni, Stefan Voda), 8. Ungheni (Ungheni, Calarasi, Nisporeni), 9. Cahul (Cahul, Cantemir), 10. Taraclia, 11. Comrat (Comrat, Ciadir-Lunga, Vulcanesti), 12. Bender (Anenii Noi, Dubasari).

Hospitals are contracted on the basis of the global budgets and the per-treated-case principle. The NHIC transfers monthly the amount set under the contract clauses. The payment mechanisms the NHIC uses in contractual relations with health care facilities have not altered since 2004, when the current health insurance system was implemented. This was confirmed during interviews with many managers of the health care facilities. Some of them do not correspond to the health care system development trends any more. Other contracting models should be implemented, especially in case of hospitals. Contracting hospitals under the Diagnosis Related Groups (DRG¹⁵) classification system, applied in the USA, Germany, Norway, France, Austria, etc., or the DBC¹⁶, applied in Netherlands, might serve as an example in this respect. These diagnosis groups describe all types of services offered by hospitals. The contract signed by the insurance company and the health care facility provides for the amount of services, types of services, tariffs and manner of payment for the provided services.

According the NHIC activity reports 320 health care facilities and drugstores were contracted in 2009 and 384 – in 2010. In 2011 187 drugstores¹⁷ and 213 health care facilities¹⁸ were contracted (in total 400). The number of contracted health care facilities is constantly increasing, mainly owing to autonomous health centers from villages, which benefit of direct contracting with the NHIC as part of a Ministry of Health's reform initiative¹⁹. We can see an enhanced flexibility of the NHIC's cooperation with health care service providers, which directly enhances the population's access to primary health care services and has already proven its cost-efficiency and cost-efficacy in many West-European states, mainly in the United Kingdom, Netherlands, Germany, etc.

LEGISLATIVE AND REGULATORY FRAMEWORK OF THE CHI SYSTEM

The compulsory health insurance (CHI) functions under Law No 1585-XIII of 27 February 1998 on Compulsory Health Insurance (amended and supplemented in 2003, 2004 and 2007) and Law No 1593-XV of 26 December 2002 on Amount, Procedure and Terms of Payment of the Compulsory Health Insurance Premiums. According to Article 6(2) of the Law on Compulsory Health Insurance "each insured individual is issued a compulsory health insurance policy under which the person may benefit of the entire amount of health care provided for in the Single Compulsory Health Insurance Program of approved by the Government and offered by all health care facilities of the Republic of Moldova".

Other regulatory acts relevant to insurance include the Law on CHIF and Methodological Norms for Application of the Single CHI Program. Both documents are revised annually. The CHIF law refers to the compulsory health insurance budget providing for revenue and expenses for the respective financial year. Under Law No 847 of 24.05.1996 on Budget System and Budget Process (Article 48) the draft CHIF law is developed jointly by the Ministry of Health with the Ministry of Finance²⁰. De facto, all work has to be done mainly by the NHIC, which was confirmed during interviews with the management of the NHIC and the MH. The Ministry of Economy has the duty to approve the respective law. The CHIF law is supplemented with the regulations on funds formation, which specifies the administration of funds by the NHIC. Then the law is approved by the Parliament of the Republic of Moldova. The

¹⁵ DRG – Diagnostic Related Groups

¹⁶ DBCs – The Diagnose Behandelings Combinaties

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¹⁸ http://www.cnam.md/cnam_php/editorDir/file/prestatori_servicii_medicale/farmaciicontractate_02_2011.pdf

¹⁹ http://www.cnam.md/cnam_php/editorDir/file/prestatori_servicii_medicale/lista_ims_contractate_21_03_2011.pdf

²⁰ <http://www.moldpres.md/News.aspx?NewsCod=4586&NewsDate=18.05.2011>

<http://lex.justice.md/index.php?action=view&view=doc&lang=1&id=328230>

methodological norms determine the health care services organization and payment principles in accordance with the type of health care provided for in the Single CHI Program. The methodological norms are revised annually depending on the accumulated amount of the CHIF for the respective year approved by the Ministry of Health and published in the Official Gazette. The Single Program is approved through a Government Decision. The Single Program used today was approved through GD No 1387 of 10 December 2007. Health care services included in the Single Program are provided by all health care facilities of the country. However the quality of the provided health care services differs considerably from one health care facility to other.

THE NHIC'S ROLE AND FUNCTIONS

The NHIC was founded through Government Decision No 950 of 7 September 2001 in order to implement the Law on Compulsory Health Insurance. The NHIC's Statute was approved through GD No 156 of 11 February 2002.

The Company has the following goals:

- Efficient organization of the CHI system;
- Securing the accessibility and universality of health care services;
- Control of the amount and quality of the provided health care services.

The NHIC has primary competences in:

1. Development of health care insurance policies;
2. Contractual relations for procurement of health care services from providers;
3. Assessment and check of the quality of the provided health care services.

The main processes related to development and improvement of health insurance policies are as follows:

1. Development of the Single Program;
2. Annual development of the CHIF law;
3. Annual development of the amendments to the Law on Amount, Procedure and Terms of Payment of the Compulsory Health Insurance Premiums;
4. List of compensated drugs.

The NHIC has a significant role in development of policies²¹. Naturally policy development should belong primarily to central political authorities, mainly the Ministry of Health. The NHIC's paramount role should be limited to contracting and assessing the health care facilities' compliance with contractual clauses. If we apply the functional analysis principles the current situation shows the existence of a conflict of interests. The responsibility for development of the insurance policy should be assigned exclusively to the Ministry of Health, preferably to a health insurance directorate. The NHIC should be involved only for consultancy and feedback.

Control and assessment activity is another continuous exercise of the TA in cooperation with the NHIC. The basic practices of assessment and control of the provided health care are carried out mainly through:

²¹ Recommendations of the NHIC functional analysis, 2006. Public Administration Reform.

1. Check of the compliance with the contractual clauses (amount, terms, cost, efficient management, etc.);
2. Review of claims and requests from insured individuals.

Claims in respect the quality and errors committed in providing health care services are collected via a hot line or online questions/requests from the official web page of the company²². However, the system of examination and addressing individual claims is insufficiently developed²³. The study does not contain data and arguments that would confirm usage of other assessment and control instruments, such as “control purchase”, unexpected controls, etc. Neither was found data on the existence of a quality assurance mechanism, similarly to the medical ISO. This mechanism would enable to maximize the efficiency of the assessment process very much, through control of compliance with the internal quality assurance systems.

Regular assessment of the provided services is performed mainly on the basis of per capita indicators and per treated case indicators. The performance assessment indicators (indicators relating to entry, process, output and the outcome) have been recently introduced in practice of contracting primary health care facilities. However, there are still no indicators for the hospital system. A standard set of quality/performance indicators should be implemented in all contracts signed with any kind of health care service providers. This would contribute to increase in efficiency and quality of the provided health care services, especially if the performance indicators would be related to corresponding incentive payments. And the NHIC has the role of assessing the compliance or results with the quality indicators.

The recent decision of the Ministry of Health on direct contracting of village health centers by the NHIC²⁴ imposes the need for additional human resources in territorial agencies. Some agencies do not have the necessary staff. This makes us suppose that insufficient human resources from territorial agencies may limit the assessment and control capacity of the NHIC on the whole.

Another duty of the NHIC consists in issuing compensated drugs setting a ceiling for commercial profit. The NHIC does this on the basis of bilateral contract with the pharmaceutical facility. According to many health care service providers (heads of specialized services, attending physicians, hospital managers), the public procurement tender procedures, required to perform centralized procurement of drugs, are extremely bureaucratic. Additional delays are incurred by court proceedings of pharmaceutical companies participating in tenders. As a result, the direct beneficiary of these health care services – patient – has to suffer. According to experience over the past years the process of procurement of essential drugs – anesthetics, antibiotics, antitumorals, etc. – is delayed by about 3 months.

Besides, some interviewed persons told about existence of the phenomenon of unofficial procurement of drugs against the lowest price existing on the market. The rationale of this phenomenon amounts to indirect increase of the number of beneficiaries. Yet the quality may not substitute the quality. Often the quality of the drugs procured at the lowest price is poor (mainly in case of drugs produced in Ukraine, Vietnam, some drugs from India, China, etc.) As a result the patient has to suffer.

²² http://www.cnam.md/?page=44&intrebare_raspuns

²³ Recommendations of the NHIC functional analysis, 2006. Public Administration Reform.

²⁴ <http://www.moldpres.md/News.aspx?NewsCod=4586&NewsDate=18.05.2011>

PACKAGE OF SERVICES PROVIDED BY NHIC

The health care services for CHI beneficiaries are provided by public and private health care facilities contracted and paid directly by the NHIC. The Single Program used today comprises:

1. Diseases and conditions that require medical assistance in accordance with the International Classification of Diseases (ISD), version X of the World Health Organization (OHW);
2. Types of health care;
3. Manner of health care provision;
4. Amount of the health care services provided to insured individuals.

Medical assistance and health care services specified in the Single Program are provided in full to all insured individuals and partially (primary and emergency health care) to uninsured individuals. The Single Program is a universal package of services determined on the basis of:

- Demographic trends;
- Morbidity specific for the population of the Republic of Moldova;
- Priorities in public health.

The Single Program also includes a few annexes with:

1. List of diseases which, after being confirmed as a new case, allow visiting directly a medical specialist of the corresponding profile from the specialized outpatient health care;
2. List of specific medical works for some specialties and/or services of surgery profile, carried out as part of specialized outpatient health care;
3. List of highly qualified health care services.

Provision of health care in case of diseases and conditions specified in the Program may have an urgent and planned character, depending on the health condition of the insured individual and on the presence or absence of the respective indications. The emergency health care is provided in all cases when failure to provide timely health care threatens the life of the patient and/ those around him or may have severe consequences on the patient's and/or public health²⁵. The planned health care is provided in cases when the patient needs health care, but the conditions mentioned for the emergency health care are not met. The amount of the health care established in the Single Program takes into consideration the type of health care and the general range of services the insured individuals have right to. Conditions for provision of health care for each level and type, the list of paraclinical investigations, manner of payment and criteria on contracting the providers are set in the Methodological Norms on Application of the Single Program. Emphasis is made on underprivileged groups and those at risk, with focus on prevention of diseases and conditions.

According to a 2006 analytical note on health, for the health care sector on the whole there are 2 types of health care service packages²⁶:

- 1) MINIMAL package of services available for the whole population irrespective of the fact whether the person is currently insured or not.
- 2) BASIC package of services from compulsory health insurance for insured individuals.

²⁵ Methodological Norms on Application of the Single Program in 2008; Order of the MH No 138/55A of 27.03.08.

²⁶ Notes on health policy. Republic of Moldova Government, World Bank, 2006.

The ranges of services included in both packages are shown in Table 7. The detailed composition of both packages is laid down in the Single CHI Program²⁷.

TABLE 7. COMPOSITION OF THE MINIMAL AND BASIC SERVICE PACKAGES.

MINIMAL service package	BASIC service package
1) Primary health care services provided by a family doctor in an outpatient health care facility or at home. 2) Consultations with specialists at policlinics and hospitals (if they are included in the list of the family doctor and on the basis of a referral from the family doctor). 3) Limited range of diagnosis analyses and elementary investigations performed in outpatient laboratories (in case the family doctor prescribes them). 4) Vaccination (under the Single Vaccination Program). 5) Emergency services in cases of a threat to life. 6) Inpatient health care for treatment in case of TB, mental disorders, cancer, asthma, diabetes, HIV/AIDS and other communicable diseases. 7) Additional services, including: (a) prophylactic measures and antiepidemic health care services provided as part of national programs included in the state budget; (b) prehospital health care in case of major surgical emergency threatening a person's life; (c) primary health care provided by family doctors, which includes health check, investigations and treatment; (d) specialized health care in inpatient conditions.	1) Prehospital emergency care. 2) Primary health care. 3) Specialized outpatient health care. 4) Inpatient health care. 5) Other health care services (care, dentistry and financial subsidies for drugs for patients with arterial hypertension).

The Moldovan health care system is mainly centered on curative services (disease treatment) and very little on prophylaxis (disease prevention) and health promotion. People are not used to be on treatment and even less to protect their health. This fact is confirmed by high incidence of noncommunicable heart and oncological diseases. For these reasons the existing basic health service package definitely needs to be changed and adjusted supported with arguments. However, the extension of the range of services of the basic package should be done gradually and with caution, giving priority not so much to the quantity of the provided services, but to their quality. This implies a series of preconditions, one of which is gradual and cautious increase of the share of contributors established on the basis of salaries.

Currently there is no document that would directly stipulate the range of health care services covered fully or partially by the compulsory health insurance. There is no flexible scheme of co-payments for health care services provided both in the primary health care and in hospitals. This indirectly encourages an excessive and unjustified consumption by consumers of health care services provided for in the Single Program.

The main users of health care services are pensioners, little children and invalids, who belong to groups of population insured by the state. They also represent the main group of consumers of expensive health care services (mainly provided in inpatient conditions)²⁸. For these reasons the extension of the range of services for persons insured by the state will automatically involve a fundamental review of financing tariffs for them.

²⁷ GD No 1387 of 10.12.2007 on Single CHI Program Approval.

²⁸ Budget Analysis of Administrative Institutions and Sector Policies in the Health Sector, 2008. CReDO.

http://credo.md/arhiva/documente/CReDO%20AnalizaBugetaraSanatate_v11%208_Eng.pdf.

During a round table organized as part of the study development and held with participation of the NHIC's representatives and two alternative private health care insurance companies, some expressed the opinion on an insufficient structuring and specification of services provided under the Single Program. According to private insurers' opinion this threatens possibilities of contracting some service packages from health care facilities considerably. For these reasons detailed review of the Single Program and reasonable structuring of covered services were suggested.

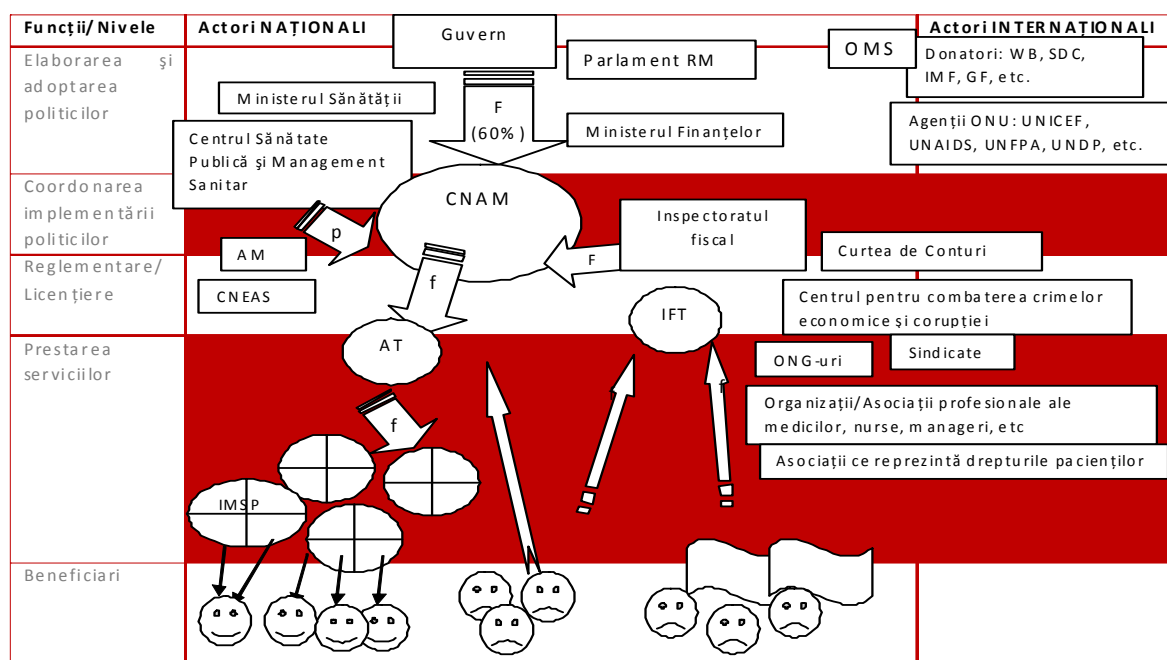
According to Article 11 of Law No 1585-XIII of 27.02.1998, the insured individual may choose the primary health care service provider and the family doctor. De facto, according to the opinion of many consumers the process is too bureaucratic so that it discourages consumers to exercise this right²⁹.

2.2. MAIN ACTORS THE NHIC INTERACTS WITH

This subchapter contains description of the main actors from inside and outside of the health care system, the NHIC interacts with. We have analyzed the levels of hierarchy, operation and financing existent between the NHIC and the actors, the intensity of cooperation as well as their formal and/or informal status. We have also analyzed the degree of competences delimitation between actors

Figure 5 shows a schematic position of actors in accordance with distribution of existing functions from the health care insurance system. The scheme was taken from the 2006 NHIC Functional Analysis Report for Public Administration Report with some changes and additions by the author.

FIGURE 5. ACTORS OF THE COMPULSORY HEALTH INSURANCE SYSTEM.



Legend:

⊕ - hospitals, polyclinics, ☞ - employers, IFT - representation offices of territorial tax inspectorates,
f – funds flow, p – policy flow, AT - territorial NHIC agencies, WB- World Bank, IMF – International Monetary Fund, GL – Global Fund, SDC – Swiss Agency for Development and Cooperation, 😊 - patients, ☹ - contributors

²⁹ Monitoring Consolidation of the Health Care System's Capacity to Prevent and Combat Corruption, 2008, 2010. CREDO <http://www.credo.md/pagini/actiuni.php?limba=rom&id=40>

(payers), WHO – World Health Organization, NHAAC – National Health Assessment and Accreditation Council, MA – Medicines Agency.

Actors the NHIC interacts with may be conventionally divided as follows:

- **International actors:** international donors and consulting agencies like the World Health Organization, World Bank, Global Fund, International Monetary Fund, Swiss Agency for Development and Cooperation, etc. These organizations have essentially contributed to training, implementation and consolidation of the compulsory health insurance system in the Republic of Moldova. Currently they continue to assess and to monitor development of Moldovan health insurance, contributing mainly by methodological and consultative support.
- Group of **central actors of the national level:** Parliament, Ministry of Health, Ministry of Finance, Ministry of Economy, Ministry of Information Technology and Communication, etc. This group of actors represents governmental administrative entities, whose function and role confine to development and adoption of various state policies, including those directly related to compulsory health insurance. Additionally, these institutions provide assessment and monitoring of the process of implementation of these policies.
- The next group of actors is represented by a number of **governmental institutions**, like the Main State Tax Inspectorate (MSTI), Court of Accounts (CA), National Health Assessment and Accreditation Council (NHAAC), Medicines Agency (MA) with health insurance policy regulation, licensing, monitoring, coordination and implementation functions. The main MSTI's responsibility consists in collection of employees and employers' contribution fees. The CA is responsible for external audit of the NHIC. The NHAAC is responsible for health care facilities' eligibility for contracting by the NHIC and the MA organizes public tenders for centralized procurement of drugs required for daily work of health care service providers.
- There is also the group of **non-Government actors**, represented by line NGOs, professional organizations/associations of doctors, nurses and hospital managers, associations representing patients' rights as well as social partners, such as the National Confederation of Labor Unions, Sanatatea Labor Union, etc.
- **Health care service providers**, both public and private ones. These actors have at their basis the function of providing services. Types of health care services provided by the contracted facilities are as follows:
 1. prehospital emergency care,
 2. primary health care, including compensated drugs,
 3. specialized outpatient health care,
 4. inpatient health care,
 5. other services related to health care,
 - highly qualified health care services,
 - home based health care,
 - treatment of uninsured individuals affected by socially conditioned diseases with major impact on the public health.

Health care services are provided to consumers/beneficiaries by means of the following actors (Table 8):

TABLE 8. TYPE OF HEALTH CARE SERVICES, CONTRACTED ACTORS AND RANGE OF PROVIDED SERVICES.

Type of health care services	Actors (contracted in 2009)	Provided services
Prehospital emergency care (PEC)	5 regional stations for emergency care and 2 departmental and private HCF. <i>Contracted by the NHIC on the basis of per capita principle.</i>	Medical surgical emergencies provided on a continuous basis from the place of accident or disease and during transportation until the patient is moved to the HCF.
Primary health care (PHC)	73 HCF, including 2 republican HCF, 20 municipal HCF (5 territorial health care associations (THCA), a Family Doctors' Center (FDC), 14 health centers (HC), 46 district HCF (35 FDC and 11 autonomous HC), 3 departmental HCF and 3 private HCF. <i>Contracted by the NHIC on the basis of per capita and per treated case principles in treatment rooms, dispensaries, and at home.</i>	-supervision of the registered persons, -promotion of a healthy lifestyle, -vaccination in accordance with the vaccination calendar and epidemiological indications, -prophylactic healthchecks, -family planning, -supervision of child development, -antenatal care, pregnant women supervision, postnatal care of perperae, -rehabilitation and recovery health care, -home-based visits and care, -organization and performance of primary antiepidemic measures in pestholes.
Specialized outpatient health care (SOHC)	86 HCF, including 19 republican HCF, 22 municipal HCF, 40 districts HCF and 5 departmental and private HCF. <i>Contracted on the basis of per capita principle.</i>	-consultation of a dedicated medical specialist, -recommendations for laboratory analyses, including the bacteriological, virological, serological and instrumental ones, -referrals to other dedicated medical specialists or hospital, in line with established regulations, -treatment, medical-social rehabilitation, dynamic supervision by the family doctor.
Inpatient health care (IHC)	HCF of the following level: - republican, - municipal Balti, Chisinau), - district, - departmental. <i>Contracting on the basis of per treated case principle.</i>	Full and partial admission to hospital (dispensary). <i>Referral system:</i> Health care for insured individuals when provision of health care services is not possible in laboratory conditions or the patient's health needs to be monitored in inpatient conditions. Additionally, based on the family doctor or medical advisory board's decision.
Highly qualified health care	15 HCF (17 republican, 2 municipal, 6 private). <i>Contracted on the basis of per service principle.</i>	Nuclear magnetic resonance (NMR), Computer Tomography (CT), Scintigraphy, Radiographic investigations, Genetic investigations, Determination of immunological parameters.
Health care provided to uninsured individuals with socially conditioned diseases	Republican specialized HCF. <i>Contracted on the basis of per capita principle.</i>	Phthisiopulmonology, Psychiatry, Narcology, Oncology, Dermatology, AIDS, Infections.

Notes: The table contains list of the main services. The integrated list of services provided as part of the CHI is much more comprehensive and is fully reflected in the Single Program.

Sources: authors' assessment

Further we will analyze only key actors the NHIC interacts with.

The NHIC's Status stipulates its subordination to the Republic of Moldova Parliament and Government³⁰. Cooperation with these 2 actors is carried out by means of the Management Board. The NHIC submits to the Parliament, the Government and the Ministry of Health its annual financial statements and reports on use of the accumulated compulsory health insurance funds as well as quarterly and annual reports to the Ministry of Finance and the National Bureau of Statistics. The main advantage of such a subordination amounts to a certain degree of autonomy for the NHIC in the sector. This enabled improving efficiency in a short time period, consequently ensuring a substantial degree of continuity and sustainability of health care reforms.

Good international practices offer also other examples of subordination of insurance agencies. The specific of the NHIC activities makes it considerably close to the Ministry of Health, which is the next key actor interacting with the NHIC. For instance, in the UK the Government agency directly in charge of the health insurance funds is administratively subordinated to the Ministry of Health. However, a premise for that consists in the transfer of the health service providers' property from the Government to the public and/or private sector. The advantage of this type of subordination amounts to more efficient harmonization and consolidation of political priorities in health insurance. Nevertheless, direct subordination of a large number of republican health care facilities as well as forensic and prophylactic medicine to the Ministry of Health does not allow its implementation for the time being.

At the same time, there is a close and continuous coordination and between the NHIC and the MH. The duty of insurance policy development is absolutely inappropriate for an agency in charge of health insurance funds management. Previously there was the Health Insurance Directorate as part of the Ministry of Health, whose primary duty consisted in development of sector policies related to insurance and regulation of the NHIC operation in the sector. During multiple structural changes of the Ministry of Health this directorate was liquidated and its duties were partly assigned to other ministerial directorates.

In the current health care system there is no independent actor that would exclusively be in charge of continuous monitoring of the corruption phenomenon in the health care system. Some NGOs, mainly involved in human rights protection have endeavored to do this sporadically and usually at the international donors' initiative³¹.

There is a need to introduce the practice of awarding a license degree to health care workers. This license should be issued for a limited period. The respective institution should hold both the autonomy in exerting its duties and the authority to sanction. The same actor could be also assigned the duty of monitoring all cases of malpraxis. And creation of an independent extrajudiciary committee meant to solve these cases would facilitate improvement of health care services provided both by doctors and by health care staff considerably.

The review of health care service providers in accordance with the structural principle reveals a high degree of complexity of the health care facilities existing in the system. For instance, there are at least 5 types of primary health care facilities

³⁰ GD No 156 of 11.02.2002 on Approval of the National Health Insurance Company's Status.

³¹ Monitoring Consolidation of the Health Care System's Capacity to Prevent and Combat Corruption, 2008, 2010. CReDO. <http://www.credo.md/pagini/actiuni.php?limba=rom&id=40>

within the primary health care. Taking into consideration that the range of the provided primary health care services differs insignificantly from one type of facility to another, this delimitation seems to be rather artificial and extremely complicated. What is of interest, though, is the legal status of the primary health care facilities. Autonomous and private health centers have a major importance. Only this kind of organization of the primary health care proved maximally efficient in the West.

We can also see the same high level of complexity in the hospital system. The multitude of republican, municipal, departmental, district and other hospitals complicate substantially their general management at the system level. Besides, they confuse beneficiaries as well. Most hospitals were built during the Soviet period, being a reflection of a vertical centralized resource management system. This proves inappropriate in a flexible market economy.

As for the highly qualified health care, the situation is in disadvantage to the public services. The private highly qualified health care market made a remarkable leap over the past years and the possibility to be contracted directly by the NHIC has only amplified this phenomenon. Competition in this area achieved maximal levels in very short time. Surprisingly yet this phenomenon has positively and considerably impacted the quality of highly qualified health care provided in public facilities³². This is definitely a benefit for consumers.

The situation with actors in charge of providing services related to socially conditioned diseases varies essentially from case to case. For instance, priorities at the global level, such as HIV/AIDS and tuberculosis are given important financial contributions from the Global Fund and other interested donors. This enabled rapid development of the respective health care facilities and considerable boost in their competitiveness both in terms of efficiency and quality. Yet, some services, mainly psychiatry and oncological ones, still have to develop in this respect. Major problems related to the same huge administrative structures requiring restructuring, absence of competition from the private system and insufficient capacities to manage these services. Consequently, resources consumption from health insurance is focused mainly on maintenance of services and very little on curative and especially prophylactic needs of beneficiaries.

As for delimitation of responsibilities between actors we can mention the following:

- Introduction of primary health care along with health insurance is the fundamental element of the reform of the Moldovan health care system. As any reform, during its implementation it encountered a number of obstacles. One of them relates to insufficient delimitation of the family doctor's competences in relation to the medical specialist. This may be explained in part by the family doctor's lack of fundamental competences, the culture of patient's referral to a medical specialist inherited from the Semasko system and medical specialists' reluctance to change.
- There is no clear delimitation of the role of supervising the quality of the provided health care services. This applies both to the primary health care and to hospitals. Apart from the recently introduced quality standards, which are incomplete for the time being for some disciplines, there are no mechanisms for monitoring and assessing the quality of health workers' practical skills. It is assumed that this function belongs to professional health care associations. In reality though professional unions have a role of guiding and continuous training of specialists and very little of sanctioning for malpraxis cases.

³² Report on Assessment of the Efficiency of CT scan at the Institute of Neurology and Neurosurgery, UNDP, December 2010.

- There are also conflicts of interests. Health unions are purely bureaucratic professional structures characterized by strong reluctance to change and progress, a low degree of adaptability and flexibility. The small size of the Republic of Moldova favors a strong interdependence of health professionals from one another. This phenomenon, very specific for the post Soviet area, may be found not just in the health care sector. Cumulatively these phenomena explain the persistence of the status quo in the health care system in terms of reform. The impact of both phenomena is directly felt in the health insurance system as well.

3. INSTITUTIONAL GOVERNANCE

This chapter analyses the structural components and functional aspects of the internal management and control bodies of the NHIC, namely: the Management Board, the Executive Directorate and the Censors' Committee. We have analyzed internal processes making part of the NHIC's activity, the vertical and horizontal decision-making from the executive directorate and the NHIC's relations with territorial agencies.

3.1. MANAGEMENT BOARD

Under the NHIC's Statute approved through GD No 156 of 11.02.2002, the Management Board (MB) is the supreme body of the company's self management. The aim of the board amounts to "supporting the interests of all employees in relations with the executive directorate of the Company and guaranteeing the correctitude and social fairness in performing the compulsory health insurance".

The NHIC Management Board is chosen for a 4 year period and is approved through a Government decision. Under the Statute, the membership in the Management Board is incompatible with the position of employee at the NHIC. The MB is headed by a chairperson and 2 deputy chairpersons. Usually the chairperson's duties are assigned to a representative of the Government. The MB includes 15 members: one representative from the Parliament and the President each, 5 representatives of the Government (of whom 2 are appointed jointly by the Ministry of Finance and the Ministry of Economy and 2 by the Ministry of Health, 3 representatives of the National Confederation of the Employers' Union of the Republic of Moldova, 3 representatives of the National Confederation of Trade Unions of the Republic of Moldova, 1 representative of the professional organization of health workers and 1 representative of organizations for patients' rights protection.

Despite the fact that the membership of the NHIC Management Board comprises a wide range of interests, one can see the functional domination to the advantage of the central governments. Patients, primary beneficiaries of the health care system are represented by a single person, namely the deputy chairperson of the association of persons affected by miopathy³³. Yet there are no representatives of patients with diseases whose treatment is of national strategic priority for public health programs, namely representatives of patients with cardiovascular diseases and/or cancer³⁴.

Health care service providers are represented by professional organization Doctors' League. However, there are no representatives of NGOs. The decision-making in respect to accession of members to the respective board is also obscure. There is no transparency for general public: it is not clear whether there are contests for selection of members to the board and what criteria for participation in this contest are.

The current nominal composition of the MB was approved through Government Decision No 720 of 18.07.2005 (MO101-103/29.07.05 Article 790) and remained unchanged until present (June 2011). The chairperson of the MB, Eremciuc Vladimir, a PM from the Republic of Moldova Communist Party (PCRM), died on 15 January 2011. No document specifying appointment of another person as the MB chairperson was found. We also found breach of the provision on the length of the MB members' mandate. Currently it exceeds the 4 years period stipulated by the

³³ Boală cronică, incurabilă, cu caracter progresiv a sistemului muscular, debut frecvent în copilărie.

³⁴ Cea mai înaltă mortalitate este înregistrată în cazul cancerelor de sân, col uterin și pulmonar. În 2009 incidența acestor cancere a fost de 226 de oameni la 100 mii locuitori.

Status of the board. Another MB member, Golovin Boris, acting in his capacity of ex deputy Minister of Health and Social Protection, has tried to exercise his powers as early as in 2009.

The main duties of the Management Board are as follows:

- a) setting the main goals for the Company's activity in the medium term;
- b) supervision of observance of the social fairness;
- c) coordination of the average tariffs for health care services and of the Single CHI Program;
- d) approval in the Government of the annual draft CHIF law, regulations on insurance and reinsurance, on the amount of premiums, manner of CHIF formation and appropriation, approval of the budget of expenditures, the Company's annual financial statements and annual reports on use of the respective funds, etc.

The MB's duties also include approval of the nominal composition of the Censors' Committee, public information about the NHIC's work, proposals on appointment (on the basis of a contest) or dismissal of the Company's Director General, etc.

The list of the MB's duties does not specify whether there are specific competences and mechanisms for supervision, assessment and monitoring of the NHIC's general performance both at the top management level and at the level of the Company's basic deliverables. We could not find out whether there were any performance indicators for the executive management and which levers to influence the board existed for cases of the NHIC's general performance noncompliance with the strategic NHIC development plan goals. Additionally, we did not identify any HNHC development strategy/plan for the medium or long term. Under the Statute the MB is summoned if needed, but no less than 4 times a year, i.e. quarterly. In extraordinary cases, the board may be summoned at the request of the Management Board chairperson, the Director General of the NHIC or the Censors' Committee. For the study analysis we used 2 minutes of the Management Board meetings: No 1 of 28 April 2010 and No 2 of 22 September 2010, summoned with a 5 months interval of each other. Under the Statute the Board's decisions are passed by a simple majority of votes of the members present at the meeting, but are not validated if it is attended by less than 2/3 of the members, i.e. 10 persons. Due to functional domination to the advantage of the central governments, this provision of the MB's Statute is risky. This is because hypothetically, in certain circumstances, decisions may be passed by 6 persons too (the majority of those 10 present, as the latter form 2/3 of the entire Board). That is why, by a simple numerical domination, the Government may enforce its will. And this conflicts with the principles good governance. According to minutes presented by the NHIC, decisions were passed by 8 members attending the meeting. Yet an additional note specifies that 2 of the attending MB members held also the voting right given to them by other 2 MB members who were absent at the meeting. It is unclear whether this procedure of "passing" votes complies with the existing legal framework.

3.2. EXECUTIVE MANAGEMENT

This subchapter analyses the structure, competences, decision-making authority and manner of operation of the NHIC executive management. Besides, we analyzed the list of the Director General's duties and responsibilities.

The operative and executive management of the NHIC is the main duty of the Executive Directorate. Under the Statute, the main responsibilities of the NHIC executive management are limited to:

- collection, record keeping and control over the accuracy of calculations and transfer of insurance premiums;
- collection of fines and financial sanctions and their distribution in the CHIF;
- control over the quality and amount of the health care provided to insured individuals;
- settlement with health care facilities;
- informational and statistical monitoring of the CHIF;
- calculation of the size of health insurance premiums, participation in development of the Single Compulsory Health Insurance Program, the NHIC's annual draft expense estimate, the reports and annual balance, etc., including their submittal to the Management Board.

The NHIC's Director General is the main manager, in direct charge of the Executive Directorate's work. He/she is elected on the contest basis and appointed for five years through a Government decision, at the Management Board's proposal. Under the Statute the Director General's main competences include:

- management of the NHIC's work and enforcement of all Management Board's decisions;
- management of assets, organization and conduct of contributions accumulation process; use of financial resources and management of investment activities;
- accounting and statistical record keeping and secretarial work;
- conduct of the staff selection and training process, appointing heads of the territorial and branch agencies; staff employment/dismissal and application of sanctions (if required); determination of the employees' salary; etc.
- cooperation with Government, community and international organizations in line with the Management Board's orders.

The Director General's decision-making authority results from the Management Board's decisions. The executive and monitoring competences seem to be clearly set forth, but there was no answer as to the question whether there were any mechanisms and instruments for practical enactment of monitoring actions (performance indicators for the NHIC's employees, job descriptions, work instructions specific for each employee's duties, specific motivation/correction/sanctioning schemes, etc.).

3.3. CENSORS' COMMITTEE

The Censors' Committee is the body controlling the NHIC's work. The Censors' Committee current nominal composition is approved through NHIC MB decision of 27 July 2005 and is formed of 7 persons³⁵. 4 Government's representatives (the Ministry of Justice, the Ministry of Finance, the Ministry of Economy and the Ministry of Health), one representative of the National Confederation of the Employers' Union of the Republic of Moldova and 2 representatives of the National Confederation of Labor Unions of the Republic of Moldova (specialists in finance, banking and insurance). The Regulation on the work of the NHIC Censors' Committee was approved through NHIC MB decision of 27 December 2005. The Censors' Committee composition is approved by the MB for a 4 years period. Similarly to the Management Board, the Censors' Committee has preserved its

³⁵ The NHIC Statute passed through GD No 156 of 11.02.2002.

current composition for 6 consecutive years, breaking the clause on the mandate length stipulated under the law.

The main responsibility of the Censors' Committee comes to supervision of the NHIC observance of legal provisions. This is done through internal control of the financial economic and investment work of the Company and timely notification of the Management Board on all bankruptcy risks, control over the NHIC's obligations to insurance beneficiaries. Controls are carried out at the initiative of the members of the Censors' Committee, at the request of the management Board or at the request of the Republic of Moldova Government and Parliament³⁶. The external control over the NHIC's general work is performed by bodies with control authority (CA, CCECC, etc.). Additionally, in 2010 the Internal Audit service was established in the NHIC, which is responsible for implementation of the financial management and internal control system³⁷. In functional terms, the direct subordination of the Censors' Committee to the Management Board, while the internal audit service is subordinated and has to report directly to the NHIC executive management is clear. The question is: why do they need a Censors' Committee if both internal and external annual audits of the Company are carried out?

3.4. NHIC – TERRITORIAL AGENCIES RELATION

This subchapter analyses the structure, competences, decision making authority and manner of operation of the territorial agencies in relation to the NHIC.

The territorial and branch agencies are subordinated to the NHIC directly. Creation, reorganization or liquidation of a TA are included among the NHIC's direct duties. Staff number, number of units and location of the TA are decided in relation to the number of beneficiaries of provided services. The TA is led by a deputy director. Save for municipalities, a TA serves 3 geographically neighboring districts. This territorial-administrative structure matches the counties structure existing at the stage of initiation of health care reforms. On average 3 coordinating specialists, each one responsible for each individual district, work in a TA. According to data presented by the NHIC, by 31 December 2010 the total number of the NHIC and TA employees amounted to 297 individuals, of whom 2010 were heads and specialists while the remaining part represented the auxiliary staff. Compared to 2009, the total number of employees amounted to 290 individuals. Despite a staff increase, according to data of the NHIC's official webpage, some TA are not fully staffed for the time being (Taraclia, Comrat, Soroca, etc.). The development goals of the health care system development strategy imply massive decentralization of primary health care facilities and creation of autonomous and private units. Under those circumstances each newly created health care facility (autonomous or private) will have the right to be directly contracted by the NHIC. Recently the Ministry of Health announced an initiative of the NHIC to directly contract village health centers³⁸. This, however, will inevitably entail considerable growth in the work load for the NHIC employees on the whole and for those of the TA in particular.

³⁶ Regulations on Work of the NHIC Censors' Committee, MB's minutes No 2 of 27.12.05.

³⁷ NHIC Order No 105-A of 09 June 2010 on Implementation of the Financial Management and Control System.

³⁸ <http://www.moldpres.md/News.aspx?NewsCod=4586&NewsDate=18.05.2011>

4. THE NHIC'S REVENUE

This subchapter analyzes the revenue part of the funds the NHIC manages, their evolution and structure, reviews aspects of social fairness among payers and identifies the main issues related to revenue formation and record keeping.

4.1. REVENUE FORMATION

The CHIF revenue is formed of premiums as percentage paid by employees and employers, premiums as fix sums paid by individuals, transfers from the state budget (to insure some categories of the population) and other revenue (fines, penalties and interest related to balances of the CHIF). The existing legislation stipulates that “the compulsory health insurance premiums shall be paid as financial contributions of sufficient amount to implement the Single Program and to carry out the insurer’s work”³⁹. The amount of transfers from the state budget to the compulsory health insurance funds to insure individuals mentioned in Article 4(4) of the Law on Compulsory Health Insurance is decided annually in the state budget law, representing a percentage share from the approved total expenses of the state budget.

In reality, the percentage share was set in 2004 as 4% - a level considered reasonable at that time to be payable by employees and employers and is gradually increased in order to meet a higher level of needs of the health care system (currently accounting for 7%). The transfers from the state budget cover the difference between the health care system needs and revenue collected from premiums paid by employees, employers and other individuals. Although the Law on Compulsory Health Insurance stipulates that “the compulsory health insurance of unemployed individuals listed under Article 4(4) shall be performed from the state budget”, the transferred sum per insured individual is much lower than the cost of the premiums paid by other categories. In the future it is planned to increase the percentage premium paid by employees and employers and to gradually decrease the transfers from the state budget until their total elimination.

4.2. NHIC'S REVENUE FORECAST

Development of the NHIC's budget is part of the annual budgeting process, with the NHIC's revenue forecasted for a short term of 1 year usually. At the same time, the Medium Term Expenditure Framework sets the level of the compulsory health insurance premiums and forecasts the average monthly salary for three years, which enables forecasting an important part of the CHIF revenue for a medium term. Of course, the relevance of these estimations depends very much on the accuracy of forecasts on the employment rate and the average monthly salary.

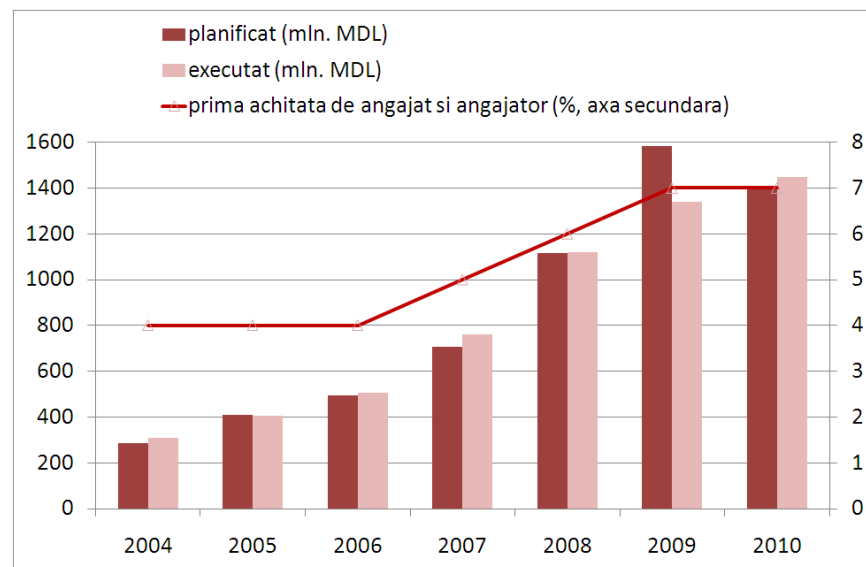
It is not very clear how the forecasts have been made so far, taking into account that the NHIC did not keep a strict record of the number of insured individuals, especially of employees. These data were provided by the NBS (the average annual number of employees) and differ from the actual number of insured employees during the year. Thus, after these data were processed by the NHIC in 2010, a 24% increase of the insured employees was recorded (174 thousand), which was immediately followed by extension of the level of population coverage with health insurance by around 10 pp. As mentioned in Chapter I this approach is not appropriate for reporting the coverage with compulsory health insurance. Moreover, there is no clear methodology for keeping the record of the categories insured at the expense of the state. For some of them data of the 2004 census are used so that the number of the population insured in accordance with these

³⁹ Single Compulsory Health Insurance Program approved through Government Decision No 1387 of 10.112.2007.

categories does not vary over many years. Definitely, these gaps influence the quality of short term forecasts. And the lack of medium term forecasts does not allow assessing the real capacities to finance the system in relation to the population's growing needs. Besides, the qualitative forecast is particularly important to set an optimal share of the health insurance premium and to change it on time, so that it should not produce an excessive burden for employers/employees and, at the same time, fit the health care system's needs appropriately.

If the amount of the transfers from the state budget has always coincided with the approved amount this is not the case of other sources of the CHIF revenue. In case of the insurance premiums paid as percentage share by employees and employers (which represented the second revenue source as importance over the years, save for 2009), differences were not very large and, most often, in positive direction, yet they reflected poor capacities in making trustworthy forecasts. The only exception was in 2009, when the economic crisis affected the number of employees (many businesses migrated to informal economy so that the number of officially registered employees decreased, even if the number of the employed population did not change considerably). Thus the employees and employers' percentage contributions were less by 15% than the forecast made at the beginning of the year (Figure 6).

FIGURE 6. INSURANCE PREMIUMS PAID BY EMPLOYEES AND EMPLOYERS.



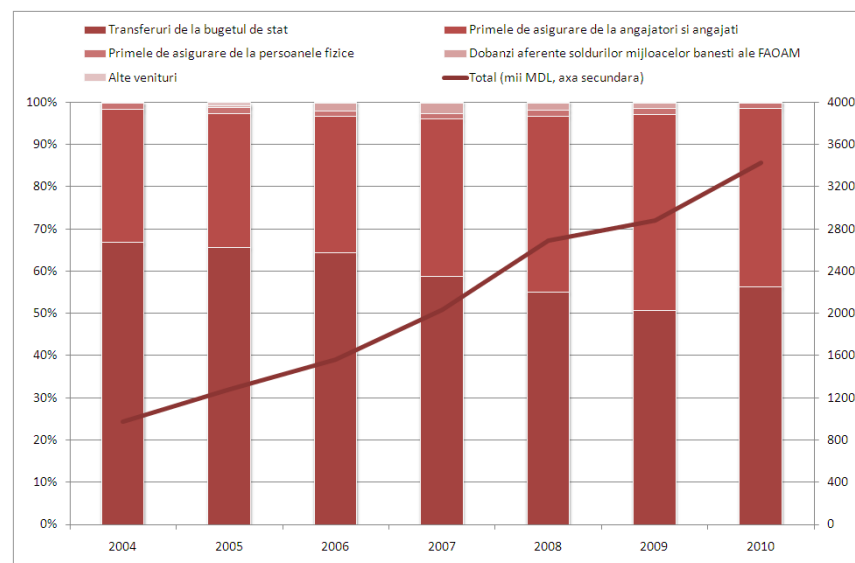
Source: NHIC and authors' calculations on the basis of the NHIC data.

At the same time, authorities were too optimistic as for insurance of self-employed persons and inactive persons of working age. In 2004, the first year of the compulsory health insurance implementation it was forecasted that about 300,000 persons would insure individually. In reality only about 10% of them purchased insurance policies. This happened because no mechanisms to ensure payment of premiums as a fix sum were developed and the population did not see clear benefits of holding health insurance policy. As a result, from the very beginning of the next year the forecast was decreased dramatically (by 50% in 2005 and 60% in 2006). However, until present, the forecast in respect to this revenue source has never fulfilled, despite facilities that were provided. Thus about 20% - 30% of the country population is not insured and this is one of the basic problems of the compulsory health insurance system in Moldova.

4.3. NHIC'S REVENUE STRUCTURE

Increase of the percentage contribution paid by employees and employers was the main source of the CHIF revenue increase in the 2004-2009 period, so that in 2009 their share in the total revenue achieved 47% (Figure 7), with a slight decrease to 42% in 2010, after increase of transfers from the state budget in a year of economic recovery.

FIGURE 7. NHIC'S REVENUE STRUCTURE AND EVOLUTION.



Source: NHIC.

In fact, 2009 was the only year when the transfers from the state budget were cut by 20% due to poor accumulation of revenue in the state budget, which caused a higher dependence of the extra-budget resources. Thus, the current financing system (based on contributions and transfers from the state budget) proved inefficient so that the reduction of transfers from the state budget was partly compensated by the employees and employers' percentage contributions. Yet this does not necessarily mean that the reverse relation is possible as well, so that a decrease of salaries may be compensated by proportional increase of transfers from the state budget. This evolution might be used to simulate the impact of financing the health insurance system entirely from employees/employers' contributions and insurance premiums as a fix amount, as planned in the long term. Thus, it is necessary to estimate the optimal period required to reduce the budget transfer/other revenue ratio to zero and the maximal level of the percentage share that employees and employers can pay, without creating additional stimuli to evade from declaring income by unbearable increase of the tax burden.

At the same time, the unemployed population, which does not fall within the categories insured by the state accounts for about 30% (the 2010 data differ largely from the previous years' data, due to different reporting approach of the NHIC and the NBS and, as mentioned previously, the NHIC's reporting approach is not the most relevant one to determine the compulsory health insurance coverage level). However, since 2004 only 2.5% to 4.5% of them have purchased health insurance policies (4.5% in 2010). Thus, their contribution to formation of the NHIC's revenue is insignificant indeed – up to 1.4%. Nonetheless, the uninsured categories also benefit of a minimal service package.

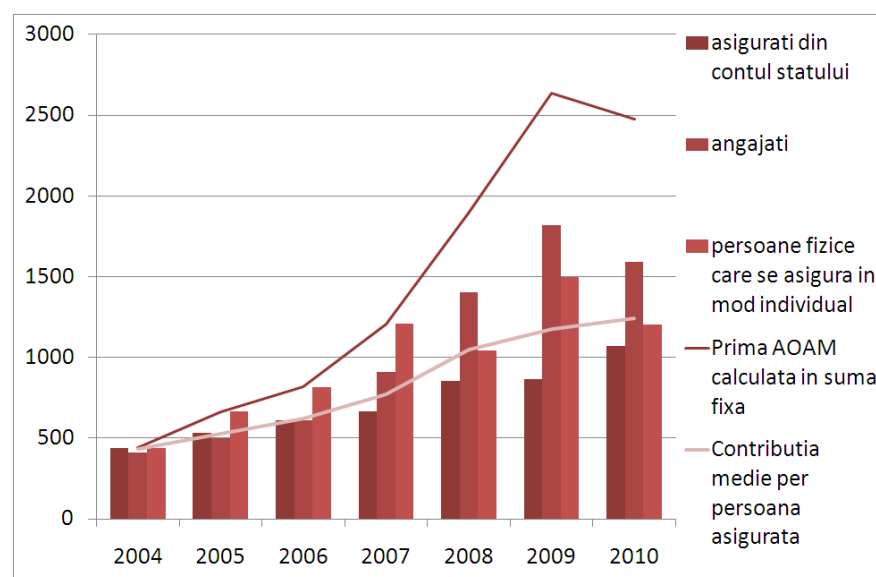
The low coverage rate of the health insurance is a major issued for the Republic of Moldova. In Central Europe countries the compulsory health insurance systems

cover the population almost entirely (over 95% in Czech Republic and Estonia). Thus, one of the Government's concerns consists in increasing the coverage of the population with the CHIF and this goal is set forth in the NHIC's 2011 Action Plan. Nonetheless, the Action Plan proposes neither specific action to achieve this goal, nor outputs to be achieved, indicators to tend to, so that it can hardly be called an action plan. Meanwhile, the most efficient solution to increase the number of insured individuals that governments can take consists in extension of the insured individuals' categories at the expense of the state. In 2010 these categories were supplemented by full time post-graduates, persons taking care of a child with I degree disability at home or a bedridden person with I degree disability from childhood, irrespective of age, mothers with 4 or more children. This had a stronger impact on the number of insured individuals than the offered stimuli (a 50% cut of the premium calculated as fix amount for private entrepreneurs and a 75% cut for farm land owners, in case of payment within three months from the law enactment). Thus, the provided stimuli seem to be rather inefficient and governments did not consider the possibility to apply sanctions to uninsured individuals, which, though harder to implement, could be more resultative.

4.4. EQUITY IN FORMATION OF THE NHIC'S REVENUE

Although the NHIC's revenue increased every year since 2004, their evolution has deviated from the logical and expected trend. Thus, even if the health insurance premium calculated as fix amount was increased from MDL 441 to MDL 2478 (5.6 times), under Article 17 of the Law on Compulsory Health Insurance (the amount of the insurance premium as fix amount is calculated by applying the insurance premium as percentage contribution to the average annual salary forecasted for the respective year on the basis of macroeconomic indicators), the sums paid by various categories of payers increased much slower: transfers per individual insured by the state – 2.4 times, premiums paid by employees and employers – by 2.7 times (Figure 8).

FIGURE 8. AVERAGE SUM PAID ANNUALLY BY VARIOUS CATEGORIES OF INSURED INDIVIDUALS FOR CHIF (MDL).



Source: NHIC and authors' calculations on the basis of the NHIC data.

Thus, all categories of population pay on average much less than the cost of the insurance policy. This makes irrelevant the calculation of this cost, which is not paid by contributors on average, save for some categories who pay fully the health

insurance policy. Even if we exclude the year 2010, when the number of employees was reported differently, the premiums paid by employees and employers are lower than the cost of the insurance policy. In this case the forecasts are neither relevant. In fact, a closer analysis of data makes one think that the forecasts could be based on data collected from public institutions and enterprises that have more than 19 employees. Of course, this approach is not correct, as a large part of employees are hired by small businesses.

Additionally, based on the collected revenue, it results that the average monthly salaries at enterprises with less than 20 employees are much lower, so that this reduces average collections per employee by down to 30%. Thus, there is a very large difference between the premiums paid by various categories of payers, including between employees with different levels of remuneration. Of course, in these circumstances those who have important contribution, which largely exceeds both the average contribution for an insured individual and the cost of the insurance policy are not satisfied, the more so as the quality of the provided services is most often unsatisfactory. Increase of the percentage premium without establishing a minimal ceiling, extension of the insurance policy to family members or other actions will only feed this dissatisfaction.

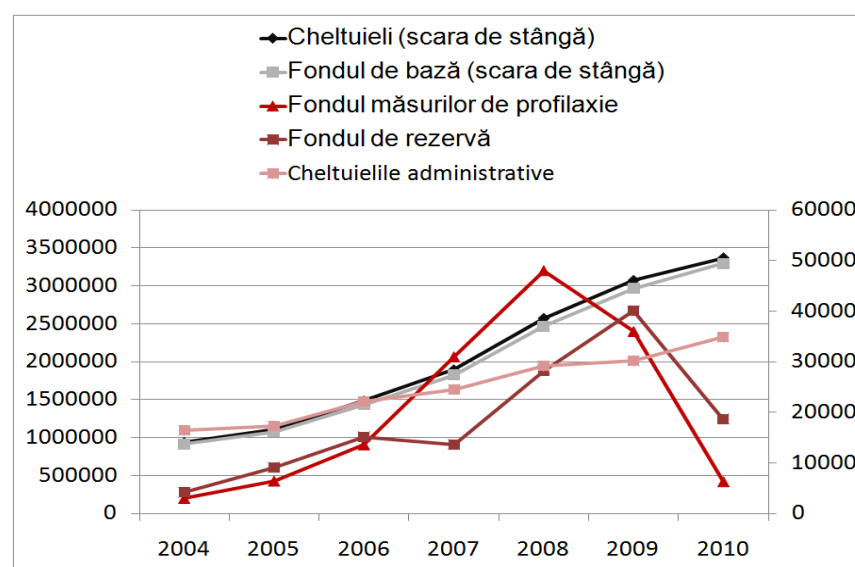
5. CHIF EXPENSES

This subchapter analyzes the evolution of expenses made from funds managed by the NHIC, the relation between these expenses and the development strategies in the health care sector and transparency in the management of expenses.

5.1. CHIF EVOLUTION

The annual amount of the CHIF expenses and their distribution by various funds, including programs and subprograms, are decided by the Parliament annually, through the Compulsory Health Insurance Funds Law. During the 2004-2010 period the amount of expenses was continuously increasing (Figure 9), growing by 75% in real terms during this period. 2009 was the only year when a MDL 192.5 million deficit was recorded as a result of spread of the world economic crisis extension in the Republic of Moldova.

FIGURE 9. EVOLUTION OF TOTAL EXPENSES MADE AND DISAGGREGATED BY THE CHIF, 2004-2010 (MDL THOUSAND).



Source: CHIF.

In their turn, the number and categories of funds the NHIC manages are set forth in the Law on Compulsory Health Insurance (No 1585-XIII of 27.02.1998) and their manner of formation in a Government decision⁴⁰. In 2004-2009 the CHIF were formed of 4 funds: the basic fund, the prophylactic measures fund, the reserve fund and the administrative expenses fund (Table 9). Through amendment made through 15.07.2010 Law No 186 and 18.08.2010 Government Decision No 743 another fund was introduced: the health care service providers' development and modernization fund. Right from the start it is worth mentioning that this decision is arguable at least and we will tackle it below. Besides, we think that it is unreasonable that the activities included under the prophylactic measures fund be financed from the CHIF. Financing these activities clearly falls within the national political priorities and not within the health insurance system and, therefore, they should be financed accordingly, from the national budget by means of specialized institutions.

⁴⁰ Decision No 594 of 14.05.2002 on Approval of the Regulations on the Manner of Formation and Management of the Compulsory Health Insurance Funds.

TABLE 9. COMPULSORY HEALTH INSURANCE FUNDS, DESIGNATION AND SHARE IN THE TOTAL AMOUNT.

Fund	Designation	Share in the CHIF (norm)
Basic fund	Coverage of expenses incurred to implement the Single Compulsory Health Insurance Program, which include: - prehospital emergency health care; - primary health care; - specialized outpatient health care; - inpatient health care; - other services related to health care.	not less than 94%
Reserve fund	- coverage of additional expenses related to urgent diseases and conditions, whose annual rate exceeds the annual average as per the Single Program for the respective year; - compensation of difference between the actual expenses related to payment for current health care services and contributions accumulated in the basic fund (expected revenue).	2%
Prophylaxis fund	- implementation of measures for reducing the illness risk, including vaccinations and other primary and secondary prophylaxis measures; - screening for early detection of illness; - financing events and activities meant to promote a healthy lifestyle; - procurement of medical appliances, equipment, drugs and consumables in order to implement measures for reduction of the illness risk and treatment in case of emergencies for public health; - other prophylaxis and illness risk prevention measures accepted for financing on the basis of projects, in accordance with the regulation approved by the Ministry of Health and the Company.	1%
Development fund	Improvement of the health care services quality and the facilities' efficiency and productivity. It is mainly used for: - procurement of efficient medical equipment and specialized medical transport; - implementation of new technologies for heating, processing of medical waste and water supply; - modernization and optimization of buildings and infrastructure; - implementation of information systems and technologies.	1%
Administrative fund	- remuneration of staff hired by the Company and territorial (branch) agencies; - coverage of travel expenses; - maintenance of the information system and organizational infrastructure; - conduct of control over health care services and respective expert inspections; - operating expenses; - procurement of fixed assets, necessary equipment, making the depreciation appropriations; - administrative and office expenses; - staff training and career development; - other work related to management of the Company.	up to 2%

Source: 14.06.2002 Government Decision No 594.

It is worth mentioning that in 2004-2010 provisions on the normative share of various funds was fully complied with (Table 10).

TABLE 10. EVOLUTION OF THE SHARE OF VARIOUS CHIF FUNDS (%OF THE TOTAL SPENT, 2004-2010).

	2004	2005	2006	2007	2008	2009	2010
Basic fund	97.5	97.0	96.6	96.4	95.9	96.5	97.8
Prophylaxis fund	0.3	0.6	0.9	1.7	1.9	1.2	0.2
Reserve fund	0.4	0.8	1.0	0.7	1.1	1.3	0.6
Administrative fund	1.8	1.6	1.5	1.3	1.1	1.0	1.0
Development fund	-	-	-	-	-	-	0.4

Source: NHIC, authors' calculations.

Analysis of the expenses breakdown (Table 11) shows that in the basic fund the main share belongs to inpatient health care and primary health care, with 50.7% and, respectively, 30.7% of the basic fund. Moreover, in real terms expenses at these two fund lines increased by about 80% and, respectively, 148%.

Essential increase in the expenses for primary health care reveals the political priorities in the area of health care, which aim at increasing the role of primary health care both in order to improve the illness prevention and to streamline the system by consolidating the family doctors' role as gate keepers. Besides, our analysis shows that the highest increase was achieved in specialized health care – by about 378%. This on the contrary indicates that the burden of treatment is passed from the primary health care to the specialized one. Thus, the number of cases when insured individuals' address specialized health care increased in the 2004-2010 period almost twice and the number of address to highly qualified health care increased exponentially in 2004-2010, by about 22 times⁴¹. In the latter case such an increase may be explained only in part by modernization of the respective services and to a greater extent by excessive usage of these services.

At the same time, the highest share in the basic fund belongs to expenses for inpatient health care. On the whole, these had a relatively modest growth (80% in real terms) compared to those for primary health or specialized care during 2004-2010. At the same time, if we compare this increase to that of the number of cases treated in hospitals (one of few indicators that measure the performance of the respective facilities quite accurately), we will see that they increased by 16%. Thus, these data serve as a very useful proxy for assessment of the efficiency of expenses for the largest component of the CHIF. And these data show that increase of expenses for inpatient health care did not reflect in improvement of the respective health care.

⁴¹ NEA report, 2010.

TABLE 11. BREAKDOWN OF THE EXPENSES MADE FROM THE CHIF BY FUNDS AND PROGRAMS (MDL, 2004-2010).

Fund/program	2004	2005	2006	2007	2008	2009	2010
Basic fund, including:	913897.4	1075292.2	1434603.2	1825506.3	2466716.1	2965326.9	3293902.4
Prehospital emergency care	99578.7	114026.7	136048.2	160151.8	233976.1	269740.3	299510.1
Primary health care	239399.5	280094.2	412679.1	547717.5	747922.5	924491.6	1010817
<i>including: compensated drugs</i>		7403.5	23814.8	40910.2	55291.2	74055.3	116848.9
Specialized outpatient health care	28994.3	59952.3	92682.8	126708.4	177278	226413.1	235619.2
Inpatient health care	545924.9	613139.2	775615.4	952845.9	1230910.3	1478444.2	1670065.2
Highly qualified health care		8079.8	17577.7	38082.7	60539.5	65545.2	75291.3
Home based health care				0	2010.6	2120.9	2599.6
Expenses for treatment of uninsured individuals affected by socially conditioned diseases with major impact on public health					14079.1	-1428.4	
Prophylaxis fund	2999.1	6448.1	13614.4	30964.2	47989.4	35968.3	6312.1
Promotion of a healthy lifestyle						424.8	2496
Implementation of actions aimed at mitigation of illness risk and performance of screening for some diseases having importance society						35543.5	3816.1
Reserve fund	4167.2	9077.1	15096.3	13606.4	28186.7	40007.6	18682.3
Coverage of additional expenses necessary to Provide health care services to insured individuals Under conditions provided by law						10008	3706.2
Coverage of expenses for provision of health care in the amount established by law to uninsured individuals						29999.6	14976.1
Administrative expenses	16411.5	17190.1	22115.1	24513.8	29124.3	30100.3	34797.5
Current expenses	13440.4	16706.9	18549.6	23777.2	24461.1	28086.5	34206.6
<i>including:</i>							
<i>work remuneration</i>	5556.4	7042.6	9117.5	12510.8	15195.8	17282.2	20838.4
<i>compulsory state social insurance contributions</i>	1445.3	1773.2	2212.5	2867.6	3347.1	3622.8	4616.6
<i>compulsory health insurance premiums</i>	103.3	131.4	170.2	286.8	418.4	551.3	659.8
<i>other expenses</i>	6335.4	7759.7	7049.4	8112	5499.8	6630.2	8091.8
capital expenses	2971.1	483.2	3565.5	736.6	4663.2	2013.8	590.9
Health care service providers' development and modernization fund							14054.6

Source: NHIC.

5.2. CORRESPONDENCE BETWEEN THE CHIF USE AND THE STRATEGIC FRAMEWORK IN THE HEALTH CARE SYSTEM

Of course, the basic fund has a dominant role in the CHIF use to ensure the accessibility and universality of health care in accordance with the health care system development strategy (2008-2017)⁴². The latter attaches a critical role to the compulsory health insurance system and treats it as an opportunity for development of the health care system: *Section II, general goal: improvement of financing and mechanisms of payment for health services; Section III, general goal: organization and provision of health care services, including in electronic form, compliant with requirements and adjusted to the population's needs; and partly Section IV, general goal: generation and ensuring resources necessary for the health care system.*

Although the strategy is written in a rather general form, the Action Plan provides for a few more specific goals, which are relevant for the NHIC and use of the CHIF by it.

Thus, action 2.3.1.3. provides for the *increase of share of the financial resources appropriated to primary health care (up to 30%)*. This goal was accomplished in 2009, with achievement of a 30.1% level, and maintained at 30% share.

Action 3.2.1. provides for the *development (along with the Ministry of Health) of a single framework for development and financing of national programs and development of the respective capacities (training)*. It seems that this action has not been implemented. As a matter of fact, we do not even believe that the NHIC should have any contribution to these actions, which are obviously beyond the area of competences of a health insurance fund.

Action 3.3.1. provides for the *institutionalization and training of quality management and monitoring teams as part of the HCF (2009)*. This goal was not achieved in 2009.

The same action provides for creation of a mechanism (procedure) for internal and external control of quality. Interesting enough the only entity responsible for implementation of this activity is the Ministry of Health. The fact that these procedures should be developed by the Ministry of Health, to whom the public HCF are subordinated and not by the NHIC, which procures and controls the quality of services provided by these HCF could be construed as a lack of the NHIC's autonomy in respect to internal and external control of quality. Of course, the NHIC's role in controlling quality will be limited to the format of the control mechanism developed by the Ministry interested in financing the work of the HCF, subordinated to it.

Action 4.1.2. provides for the *improvement of the technical and material basis, including equipping the HCF with transport*, with the Ministry of Health and the NHIC being responsible for this.

In this context, we can also remember of creation of a new fund (development fund) in 2010. The financial means of this fund are appropriated on the basis of projects, before the Ministry of Health (!) and public health care facilities. Criteria and manner of selecting and implementation of investment projects are established in the regulation approved by the Ministry of Health (!) and the NHIC⁴³. In other words the Ministry of health submits projects and decides on criteria and manner of selection and implementation of these projects, which are financed by the NHIC.

⁴² Health care system development strategy for 2008-2017.

⁴³ Decision No 594 of 14.05.2002 on Approval of the Regulations on the Manner of Formation and Management of the Compulsory Health Insurance Funds.

However, in terms of economic efficiency it is unreasonable that the NHIC, which procures health care services from HCF, should finance procurement of equipment for them, etc. And it is absolutely unreasonable that the taxpayers, who pay taxes to the NHIC for it to procure services on their behalf, should finance development of the HCF they procure services from. Thus, not only the clients purchase health care services by means of the NHIC, but also “disinterestedly” finance development of the technical and material basis of “enterprises” they purchase services from. Moreover, such a practice represents an example of unfair competition, of discrimination of private HCF by supporting their public competitors.

It is also clear that the NHIC is not capable to exercise its autonomy when using funds in this direction, since the process is influenced and “seized” by the Ministry of Health.

It is unimaginable that a private health insurance fund should finance modernization of service providers, rehabilitate buildings they work in, etc. without obtaining the title of co-owner as a result of such an investment and offer additional benefits to its clients from whose money it carries out these “investments”. Yet exactly this happens in case of the NHIC, which in this case, has the Ministry of Health as beneficiary and not the insurance premium payers: *transmission of goods purchased by the NHIC from the compulsory health insurance funds under the ownership of the public health care facilities designated as established by the Government or the Ministry of Health (!!! – n.n.) is carried out free of charge, in accordance with the Regulation on Manner of Transmission of State Enterprises, Organizations, Institutions, their Subdivisions, Buildings, Premises, Fixed and other Assets, approved through 9 October 1995 Government Decision No 688*⁴⁴. Thus, without even willing that, taxpayers finance rehabilitation of and development of public HCF through insurance premiums.

5.3. TRANSPARENCY IN THE CHIF USE

Given the aforementioned the situation with the internal control over the CHIF usage represents an issue of concern.

The external audit carried out by the Court of Accounts outlined a series of irregularities in how the CHIF are used, although, on the whole, it appreciated the NHIC’s work rather positively⁴⁵. Therefore, the reports of the Court of Accounts make us conclude that the external audit found essential issues in 3 major areas of systemic importance:

- Contractual relations with the PHCF and securing control over them – different approaches to PHCF of the same level when contracting health care services provided by non-accredited PHCF.
- Functionality of the internal control in the NHIC – irregularities in operation of the internal control system of the NHIC and PHCF (lack of written procedures when implementing the internal control system as well as failure to identify risks that could influence their activity, etc.), with particular risk posed by absence of performance indicators for experts who check the execution of the NHIC’s basic duties, such as: check of the amount of services, terms, quality and cost. There are neither written policies nor procedures in respect to control over the management of financial means paid for services contracted from the compulsory health insurance funds.

⁴⁴ Ibidem.

⁴⁵ See also the unqualified opinion on the report on use of the compulsory health insurance funds in 2009, Court of Accounts, 25.06.2010 Decision No 46.

- Expenses planning (there are programs where the planned resources are constantly underused) and prophylaxis fund.

Besides, the Court of Accounts' report highlights irregularities made during procurement of individual protection materials to combat the A (H1N1) flue, with deviations in respect to quality and breach of stipulated terms, from the reserve fund and during construction of Ungheni TA office⁴⁶.

In this context it is worth mentioning that the NHIC's internal audit service (IAS) was established through amendment introduced in 07.11.2002 GD No 1432 "On Some Actions for Implementation of the Compulsory Health Insurance" through 10.09.2009 GD No 559. Nevertheless, the respective service seems to have no set of performance indicators for assessment of the way the CHIF are used (or at least the NHIC refused to present them) and the format in which the report on the work carried out by the IAS was provided to us makes impossible to create a holistic or at least partial picture of the results of the internal audit carried out by the IAS in 2010. Maybe this issue will also be addressed through implementation of the 2010-2011 Action Plan on implementation of the financial management system and control in the NHIC⁴⁷.

⁴⁶ Analysis of administrative expenses shows a considerable decrease of capital investments as from 2008.

⁴⁷ 9 June 2010 NHIC's Order No 105-A.

6. CONCLUSIONS AND RECOMMENDATIONS

INSTITUTIONAL FRAMEWORK THAT DOES NOT ENSURE OPTIMAL EFFICIENCY OF HEALTH INSURANCE

Since the health insurance is the main driving force for operation of a fully fledged health care system, streamlining the insurance system is impossible without reformation of the health care system. The analysis of the institutional framework covered the structure, functions and mechanisms for financing the Moldovan model of health insurance in the context of other existing models, the service package provided by the NHIC as well as main actors the NHIC interacts with. The study revealed a structural and functional complexity of the health sector, which entails massive costs for maintenance of the excess of infrastructure; insufficient functional delimitation of duties related to policy development of and health care system funding between the NHIC and MH; service package insufficiently adjusted to the population's needs; unsatisfactory quality of contracted health care services; inadequately regulated health workers' individual professional performance; imperfect policies of accreditation by the NHAAC; etc. Analyzed on the whole these issues influence considerably the NHIC's role as the main funder of the health care system. For these reasons the proposed recommendations related mainly to the whole health care system, not only to the Company.

In light of the aforementioned we recommend:

- Consolidation and exclusive delegation of functions of insurance policy development, coordination, synchronization, monitoring and assessment to a special directorate from the MH.
- Review of the strategic framework from the health care sector in order to consolidate the NHIC's duties in respect to CHIF management and legislative and regulatory protection with increase of the NHIC's autonomy against political influence of the Ministry of Health and public authorities.
- Revision of the policies for accreditation of health care facilities by the NHIC.
- Non-involvement of the NHIC in funding the procurements made by health care service providers through liquidation of the health care service providers' development and modernization fund.
- Non-involvement of the NHIC in other activities that breach the activities directly related to the compulsory health insurance (observance of item 10 of the NHIC's Statute, 11.02.2002 GD No 156).
- Implementation of mechanisms for supervision, assessment and sanctioning in case of breach of individual performance by health care workers. In this respect it would be good to introduce a license for health care workers to practice their profession, and to establish an optimal mechanism for inspection, assessment, monitoring and solution of cases of malpraxis.
- Structural and administrative optimization of health care facilities to mitigate the excess of infrastructure consuming a considerable amount of funds collected from insurance. It is necessary to redirect funds towards highly performing medical technologies, to implement evidence-based good practice and instruments for monitoring and control of the provided health care services.
- Detailed review of the service package provided by the NHIC as part of the Single Program as well as strict and justified structuring of the covered services. However, the extension of range of services automatically entails fundamental review of the financing tariffs.

- Continuous study of the possibility to cautiously liberalize the health insurance market with appropriate regulation of the respective process by the state.

IRREGULARITIES IN THE GENERAL MANAGEMENT OF THE NHIC

The NHIC has a paramount role in health insurance performance. Of course, results of this process are not exclusively determined by the NHIC, they also depend on the success of the health care sector reforms, features of social and economic development of the country, etc. Accordingly, the NHIC should address many of these aspects along with other important public actors. Some of them do not depend on the NHIC in general. Some progress can be achieved by improving the institutional governance and executive management of the Company. This study highlighted a range of irregularities related to the following major issues: internal institutional governance, including assessment of internal performance of the NHIC and relation with service providers. Both aspects have an important impact on the efficiency and control over the usage of the CHIF. The following recommendations are aimed at removing the aforementioned negative issues:

INTERNAL INSTITUTIONAL GOVERNANCE

1.1. Consolidation and improvement of the way of operation of the Management Board (MB):

- Enhancing transparency in the decision-making in respect to the accession of members to the NHIC Management Board.
- Observance of the clause on the length of the mandate of the MB members stipulated in the Statute and Regulations on its operation.
- Review of the numerical and functional composition of the Management Board, namely:
 - Inclusion of representatives of patients with diseases whose treatment is of national strategic priority for public health programs (for instance: representatives of patients with cardiovascular diseases and/or cancer).
 - Inclusion of representatives of line NGOs.

1.2. Improvement of internal control and transparency:

- Development and practical implementation of mechanisms and instruments for supervision and control of the individual performance of all NHIC's employees: performance indicators, work instructions specific for each employee's duties, specific motivation/ sanctioning schemes for non-compliance, etc.
- Ensuring transparency of information on external data through publication of the respective reports on the NHIC's website and maintaining a permanent dialogue with line stakeholders (in this respect they might need to create a civil board under the NHIC).

STREAMLINING THE CHIF USE BY CONSOLIDATING THE LEVERAGES RELATED TO SERVICE PROVIDERS

- New schemes are required to contract providers, both in the primary health care and in the inpatient health care. For instance, introduction of such modern models of contracting hospitals as DRG/DBC could help considerably to optimize the operation of the hospital system.
- Function of assessment and control of contractual provisions between the NHIC and health care service providers need to be functionally strengthened and optimized. Additional instruments for stricter assessment and control of the provided quality of health care services are

required. In this respect it would be good to include the performance indicators for contracted services in all contracts with health care facilities.

- The NHIC (further possibly with other insurers) should develop and adopt a rating of service providers based on its own monitoring and information provided by the CCECC in respect to level of corruption, which would underlie the service payment component from contracts concluded between the NHIC and HCF. Besides, making expenses more efficient, such a system would contribute to competition between various HCF and improvement of services provided by HCF.
- Many providers consider that centralized drugs procurement procedures are excessively bureaucratic and inefficient. It is necessary to simplify the methodology on this activity and to optimize logistics for organization of public tenders, with a mandatory emphasis on the quality of procured drugs.

LOW POPULATION'S COVERAGE BY HEALTH INSURANCE AND DEFICIENT FINANCING OF THE SYSTEM

Despite implementation of the compulsory health insurance in 2004 about 20% - 30% of Moldovan population is still uninsured. Of course, this along with a large number of categories of individuals insured from the state budget impacts on the financing of the system in general, so that Moldova is ranked very low in terms of public health expenses per capita. Additionally, this creates an excessive burden and unfairness for those who contribute. Thus, those who are not constrained to pay health insurance premiums avoid to do so both for financial reasons (low income do not allow procurement of insurance policies) and for non-financial ones. The fact that the current system is perceived as an inefficient and unfair, that the quality of services does not correspond to the populations' expectations and needs, existence of minimal health care service package guaranteed by the state, the possibility to buy and activate health insurance policy at any time of the year demotivate the population to participate in the current health insurance system. There are no instruments for stimulation of discipline in health insurance. We think that it would be good to implement and consider the following options:

TO INCREASE THE HEALTH INSURANCE COVERAGE

- Consider collection of the health insurance premiums, including on the basis of information obtained from income declaration.
- Requirement of purchasing insurance policy when registering real estate/property/cars, registration of individual enterprise. These categories of persons are not the most vulnerable and most likely have resources to purchase an insurance policy.
- Activation of the insurance policy within a certain term from its procurement. This is necessary to exclude the risk that the insurance policy will be purchased only if it is needed, when the expenses to be incurred are higher than the cost of the insurance policy. Of course, one should consider exceptions for certain categories of population: students who graduate during the year, dismissed individuals or those who finish a service during the year.
- Extension of health insurance over the family members of some categories of population (for instance, husbands/wives, who do not work).
- Wider application of sanctioning methods for those who do not contribute to health insurance system, not only of incentives, which proved inefficient.
- Improvement of services, elimination of corruption could motivate the population to get insured and this could be achieved through market liberalization.

TO MOTIVATE EMPLOYEES

To motivate employees and to eliminate grievances equity has to be ensured in the current system. Thus the following actions may be considered:

- Maintenance of the percentage premium for employees or even its increase as planned, but setting a maximal ceiling for contribution.
- Creation of personal accumulation accounts in which a part of contribution will be accumulated (either that of a certain set limit or a certain percentage of the total contribution).
- Extension of health insurance to payer's family members with contribution above an established ceiling.
- Extension of health care services and/or compensated drugs for persons whose contributions exceed a certain ceiling.
- Extension of the insurance period after leaving a job correlated with the period when payments to the CHIF were made. Often persons who are dismissed do not purchase immediately insurance policies and in case they use health care services during short periods from deactivation of the policy they have to pay the cost of services integrally, even if previously they had contributed much and did not use these services. Another possibility could consist in using money accumulated in personal accumulation accounts for a short period from dismissal.

TO INCREASE THE NHIC'S REVENUE

- Percentage deductions into the CHIF from the excise taxes for tobacco products. The risk of illness and starting to use health care services by smoking individuals is higher; accordingly, this action would ensure a higher degree of fairness.
- Review and reduction of the number of categories of persons insured by the state.
- Estimation of the impact of providing current stimuli (reductions of the insurance premium with the fix amount) on the number of individuals insured at their own expense and elimination of those with minor impact.

TO STREAMLINE EXPENSES

- Introduction of copayments (possibly means-tested or for certain categories of individuals insured by the state) to diminish the abuse of the respective services.
- Equilibration of inpatient and specialized services by introducing stricter control of their use by beneficiaries of the compulsory health insurance system.
- Consolidation of preventive services, with emphasis on servicing the patient in the primary health care system.
- Consolidation of the PHC service should include appropriate delimitation of the family doctor's duties in relation to the medical specialist's.

NEED TO CONSOLIDATE THE CAPACITIES OF INVOLVED PLAYERS

for the health insurance system to operate well and for the reforms to be successfully implemented we need human, financial and technical resources as well as a clear delimitation of responsibilities between various actors and a total understanding of the context the current health insurance system operates in. Currently due to the fact that some duties of the NHIC do not relate to its responsibility directly, that the responsibilities are scattered among various institutions, an inefficient system has formed and ultimately there is no clear understanding of the current situation. In the context of the proposed recommendations consolidation of the involved institutions' capacities is of primary importance because this determines the efficiency and fairness of passed decisions. Thus, we need:

- To keep a stricter record of the insured individuals and payers to the CHIF. Data collected currently do not offer a clear understanding of the situation, so that they could underlie assessment of fairness and the expected impact on some reforms/improvements in the system.
- To develop some mechanisms for forecasting indicators relevant for the CHIF. This should be the duty of the Ministry of Health and the Ministry of Finance.
- To make short-term forecasts that would enable estimating the optimal level of premiums in the percentage amount and in the fixed amount as well as the optimal term for gradual increase of the health insurance premium. The premium as percentage amount does not necessarily need to represent the average size in a group of countries (as planned), but it should reflect financing needs and capacities, without detriment to the equity in contributions.
- To monitor the evolution of the CHIF. Use of some CHIF is permanently under the planned level and their content and/or manner of planning need to be reviewed.
- To develop written procedures and list of performance indicators for control over usage of the CHIF by service providers and for internal audit of the NHIC's work. This responsibility has to belong to the NHIC and the Management Board (its component should be amended with a view to reducing the political influence and a fuller participation of beneficiaries) and not to the Ministry of Health.
- To verify whether the current number of staff hired in territorial agencies can deal with the increase in the work load that will inevitably result from increase of the number of the health care facilities contracted directly by the NHIC.